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NURSE CORPS TRAINING IMPORTANCE SURVEY REPORT

June 1992

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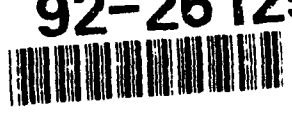

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13. ABSTRACT (Maximum 200 words)

The purpose of this study was to assess the introductory training needs of Navy Nurse Corps (NC) officers who care for inpatients in the specialties of orthopedics, obstetrics/newborn, and psychiatry. The scope was limited to 25 small and medium-sized inpatient medical treatment facilities stateside and overseas. The survey identified for each specialty: the basic entry-level tasks/knowledge/skills;the level of training needed to perform these tasks and skills; and how well nurses performed these tasks and skills. Additional training issue questions addressed three areas: support and encouragement for specialty training; reported training levels; and patient care coverage in more than one specialty area. Findings support the Navy Medical Department's concern for identifying methodologies for providing entry level training for NC officers in these specialties.

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In addition, the following individuals were critical to the preparation of the Nurse Corps Training Importance Survey and successful analysis and preparation of this report:

Ms. Tammy Heppner - Project Statistician

Mr. Henry Gorden - Project Analyst

Executive Summary

Purpose

The purpose of the Nurse Corps Specialty Training Importance Survey (TIS) was to assess the introductory training needs of Navy Nurse Corps (NC) officers who care for inpatients in the specialties of orthopedics, obstetrics/newborn, and psychiatry. The scope of the study was limited to 25 small and medium-sized inpatient medical treatment facilities stateside and overseas. The survey identified for each specialty: the basic entry-level tasks/knowledge/skills; the level of training needed to perform these tasks and skills; and how well nurses performed these tasks and skills. Additional training issue questions addressed three areas: support and encouragement for specialty training; reported training levels; and patient care coverage in more than one specialty area.

Methodology

The survey was developed by NODAC, HSETC, and the Nurse Corps subspecialty advisors to the Surgeon General for Orthopedics, Nurse Midwifery, and Psychiatry. It was mailed to a population of approximately 642 Medical and Nurse Corps officers during the first quarter of FY92. A total of 413 (64%) usable responses were returned. Descriptive statistics were used to interpret the data. For purposes of this report, the findings represent the sample.

Findings

Fifty orthopedic tasks, 94 obstetric/newborn tasks, and 92 psychiatric tasks were recommended for training at the *Hands-On/Thorough Knowledge* level. One orthopedic task was recommended to be taught at the *Familiarization* level. Only nine tasks, eight in orthopedics and one in obstetrics/newborn, were given a mean performance rating of below average. Twenty-eight additional tasks/knowledge/skills, five orthopedic, 12 obstetric/newborn, and 11 psychiatric, were identified by write-in responses.

Staff nurses and supervisors indicated that nurses were encouraged to seek additional training in the specialties at least to a limited extent. Staff nurses reported limited availability of financial and manpower resource support for training in all three specialties. Supervisors said financial and manpower resources were available to a moderate extent for all three specialties.

Both groups responded that the extent nurses sought additional training in preparation for current or projected reassignments in orthopedics and psychiatry was limited. Staff nurses reported nurses sought specialty training in obstetrics/newborn to a limited extent, while supervisors indicated nurses sought specialty training in obstetrics/newborn to a moderate extent.

At least 30% of the staff nurses and division officers in each specialty area indicated that they had some weeks of formal training. Overall, the number of NC officers who had master's degrees or certifications from the national organizations such as the American Nurses Association (ANA) and the specialty organizations had low representation except for the Nurses Association American College of Obstetrics and

Gynecology (NAACOG). Approximately 9% of the staff nurses and 25% of the division officers possess this certification.

Seventy-three percent of the staff nurses assigned to hospitals with less than 98 beds provided care to at least two types of specialty patients. At least 40% of the NC officers assigned to Nurse of the Day (NOD) duty, stand this watch in other specialty areas than their own. Twenty-five percent of the staff nurses indicated they provided after-hours coverage for at least one specialty area outside of their usual specialty assignment.

Conclusions

The Navy medical department's concern for identifying methodologies for providing entry level training for NC officers in these specialties is validated by the number of tasks recommended for training and the tasks identified by write-in responses. The opinions of staff nurses and supervisors that encouragement and support for obtaining this specialty training were available from a limited to moderate extent suggests that the facilities may not be able to provide the specialty training with the existing manpower and financial resources. These findings might also explain the responses that nurses only seek specialty training to a limited or moderate extent. The small percentages of NC officers who hold certifications in the national specialty organizations or masters' degrees in the specialties indicate that facilities probably have limited numbers of expert resources to conduct their own training.

The Navy medical department faces a challenge of balancing the complex patient care demands for specialization with the necessity of training clinically flexible

NC officers who can be assigned to small and medium-size facilities in both isolated and overseas locations. This dilemma is clearly illustrated by the percentages of NC officers providing care or supervision in more than one of these unique specialty areas.

Recommendations

- Use findings to develop curricula that support entry level training for NC officers in orthopedics, obstetrics/newborn, and psychiatry.

- Target the scope of training that will prepare NC officers for the number of unique specialties required for projected assignments.

- Circulate this report to medical treatment facilities and training organizations to supplement existing orientation and training programs.

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List of Tables and Figure

Purpose

The primary purpose of the Nurse Corps Specialty Training Importance Survey (TIS) was to assess the introductory training needs of Navy Nurse Corps (NC) officers who care for inpatients in the specialties of orthopedics, obstetrics/newborn, and psychiatry. The scope of the study was limited to small and medium-sized inpatient treatment facilities stateside and overseas. The secondary objective was to collect information for HSETC to identify alternatives for providing introductory training for NC officers in these specialty areas. The job-task inventories identified in the TIS will provide the basis for developing curricula to support these alternatives.

Background of Study

The Nurse Corps Retention and Recruitment Task Force was chartered in September 1989 by RADM Hall, Director Navy Nurse Corps, to address numerous issues which affect NC retention and recruitment. Lack of training for NC officers who work in the specialty areas of orthopedics, obstetrics, and psychiatry was targeted as a potential contributor to poor retention. The NC Retention Subcommittee examined this problem not only as it related to retention but for the impact on preparing NC officers for entry into these specialty areas. The subcommittee defined the problem:

> The majority of National League of Nursing (NLN) accredited nursing programs from which Nurse Corps officers accessions are drawn follow a "modified integrated curriculum" with reduced or eliminated clinical experience in specialty areas such as orthopedics, obstetrics, and psychiatry. Specialty training for nurses available at medical treatment facilities is inconsistent and often depends heavily on local initiatives and assets (Bureau of Medicine and Surgery (BUMED) 1991, p. 1).

In June 1991 BUMED tasked HSETC to develop a proposal containing cost effective recommendations for providing training to meet this need. In keeping with the Department of the Navy's overall strategic goal to ". . . continuously improve the quality of our military and civilian work force through fact-based, innovative systemic changes affecting recruitment, training, and quality of life. . ." (Department of the Navy (DON) 1992, p. 2), HSETC requested NODAC conduct a survey assessing the training needs of NC officers in these specialty areas.

Questions

The survey addressed the following questions.

1. What are the basic entry level tasks, skills, and knowledge needed by NC officers to perform in the specialty areas of orthopedics, obstetrics/newborn, and psychiatry?

2. What level of training do NC officers need to perform tasks and skills in the specialty areas of orthopedics, obstetrics/newborn, and psychiatry?

3. How well do nurses perform tasks and skills in the specialty areas of orthopedics, obstetrics/newborn, and psychiatry?

4. To what extent do NC officers perceive specialty training is supported and encouraged at small and medium-size medical treatment facilities?

5. To what extent do NC officers assigned to small and medium-size medical treatment facilities seek specialized training in preparation for current or projected assignments?

6. How many weeks of formal training have NC officers received in these specialty areas?

7. What certifications and/or graduate levels of education have NC officers obtained who are working in these specialty areas?

8. What percentage of these NC officers are providing after-hours coverage in specialty areas in addition to their routine work areas?

Glossary

The following definitions and acronyms may be useful in understanding the remainder of this report.

CONUS/OCONUS - Limits of the continental United States of America/Outside limits of the continental United States of America.

Facility Type - The medical treatment facilities classified by facility type as defined in the Fiscal Year 1990 Navy Health Care Planning Matrix. Family Practice hospitals are those hospitals which have physician residency programs in family practice. The other three facility types included in this survey are defined by their bed size, i.e., 98 Plus Bed-Size, 50-98 Bed-Size, and Less Than 50 Bed-Size.

Manpower, Personnel, and Training Information Systems (MAPTIS) - The aggregate of the separate but interrelated Automatic Data Processing (ADP) information systems that support the Navy's total force management. Provides information about the officer, billet, and command.

Mean - The sum of the responses divided by the number of respondents.

N - Number of members in a population.

n - Number of respondents in a sample population.

n - Number of respondents in a limited portion of the total sample.

Subspecialty code (SSP) - Five characters consisting of four numerals and an alphabetic suffix. The Officer Subspecialty System is an integrated manpower and personnel classification and control system which establishes criteria and procedures for identifying officer requirements for advanced education, functional training, and significant experience in various fields and disciplines.

TIS - Training Importance Survey.

Methodology

Survey Design and Development

The survey instrument was based on instruments previously developed and tested by HSETC and NODAC for assessing the effectiveness of enlisted "C" schools. Past surveys were mailed to supervisors and job incumbents with specific "C" school training to provide data to develop or revise the content of the training program for medical and dental technician specialties (Gottesman 1985, p. 31).

For this study, HSETC and NODAC classified orthopedic surgeons, obstetric/ gynecology surgeons, psychiatrists, nurse midwives, directors and assistant directors of nursing service, and nursing service department heads and division officers as supervisors. Staff nurses working in these three inpatient specialties were classified as job incumbents.

The job-task statements were initially developed using existing orthopedic and neuropsychiatric technician curricula and a 1990 Nursing Officer Occupational Task List

from the Canadian Armed Forces. The job-task statements were revised and finalized in a workshop of experts and representatives from HSETC and NODAC using their expertise and extensive review of curricula and standards from each specialty's national organization. Training issue questions were developed in response to input from the Nurse Corps Retention and Recruitment Task Force (BUMED Code 5, 1991).

The TIS instrument was divided into three sections: (1) Personal and Job Background Information; (2) Task Inventories for each of the three specialties; and (3) Training Issues. Background characteristics of the respondents included social security number, designator, grade, job title, type of facility, and location (CONUS or OCONUS). The task inventory contained 57 orthopedic nursing, 99 obstetrical/newborn nursing, and 94 psychiatric nursing job-task statements. The training issue section contained nine questions.

The survey instrument was pretested by administration to 15 medical and nurse corps officers working in each specialty at Naval Hospitals Camp Lejeune and Cherry Point. The pretest provided a means of detecting and solving problems in the clarity and administration of the instrument and identifying additional tasks or skills for inclusion.

Survey Population and Data Collection

The Fiscal Year 1990 Navy Health Care Planning Matrix contains manpower and health care beneficiary statistics. This reference was used to identify 25 small and medium-sized medical treatment facilities world-wide. Facilities were included only if

NC officers worked with inpatients in the specialties of orthopedics, obstetrics/newborn, and psychiatry.

Medical corps officers and nurse midwives at these facilities were identified in the Manpower, Personnel, and Training Information Systems file (MAPTIS) by the subspecialty codes (SSP) of orthopedic surgeon, obstetric/gynecology surgeon, psychiatrist, and nurse midwife. Subspecialty codes were not used to identify NC officers because HSETC was interested in assessing the training needs of all NC officers assigned to these areas, regardless of whether they possessed a subspecialty code. After excluding NC officers in billets of nurse anesthetist, ambulatory care nursing, critical care nursing, emergency care nursing, perioperative nursing, and education and training, a potential list of NC officer participants was identified.

Since the MAPTIS does not identify the ward or patient care unit assignments of NC officers, it was difficult to establish a finite population for the NC officers. This problem was solved by requesting the directors of nursing service at each facility to verify the population lists to ensure the participant was actually assigned to one of these three specialty areas.

In November 1991, NODAC mailed the survey to 984 medical and nurse corps officers. After verification by the directors of nursing service, NODAC finalized the population (N) at 642. NODAC closed the survey at the end of February 1992 with a total sample (n) of 413 responses (64%). Table 1 displays the population, sample, and return rates.

Table 1

Population, Sample, and Return Rates of the Training Importance Survey for Nurses

Job Title	Population (N)	Sample (n)	Return Rate
Senior Nurse Corps Leader[a]	59	54	92%
Division Officer	64	47	73%
Staff Nurse	342	214	63%
Orthopedic Surgeon	65	37	57%
Obstetric/ Gynecology Surgeon and Nurse Midwife	72	37	51%
Psychiatrist	40	24	60%
Total	642	413	64%

[a] Combined groups of Directors of Nursing Service, Assistant Directors of Nursing Service, and Nursing Service Department Heads

Facility Type

Participants from 25 medical treatment facilities responded. A list of the facilities and the specialty areas included is presented in Appendix A. The presence of specialty areas in each facility was determined from the population lists submitted by the directors of nursing service. Orthopedic nurses came from 24 of the 25 facilities.

Obstetric/newborn nurses came from 22 of 25 facilities. Psychiatric nurses came from 19 out of 25 facilities. Table 2 presents the distribution of respondents by type of facility. The majority of the officers came from Family Practice and 98 Plus Bed-Size hospitals.

Table 2

Percentage of Respondents by Type of Facility

Job Title	Type of Facility			
	Family Practice	98 Plus Bed	50-98 Bed	Less than 50 Bed
Senior Nurse Corps Leader[a] (n=54)	19	31	19	32
Division Officer (n=47)	28	32	25	15
Staff Nurse (n=214)	30	35	18	17
Orthopedic Surgeon (n=37)	43	32	5	19
Obstetric/Gynecology Surgeon and Nurse Midwife (n=37)	24	35	13	27
Psychiatrist (n=24)	29	38	17	17

[a] Combined groups of Directors of Nursing Service, Assistant Directors of Nursing Service, and Nursing Service Department Heads

Note. Percentages may not total 100 due to rounding.

Limitations

The findings reported are not to be generalized to all medical treatment facilities or medical department officers unless specifically stated.

Survey Analysis

The data were coded, stored on computerized data tape, processed, and analyzed using the Statistical Package for the Social Sciences (SPSSx). To achieve the purpose of this study, descriptive statistics for all research questions were obtained (i.e., frequencies, means, and standard deviations).

Respondents were asked to comment on any aspect of the survey and to identify additional training needed by nurse corps officers in the three specialty areas. Comments were sorted by job title and type of facility and edited to ensure confidentiality of respondents. Additional training comments are included with the task inventories in Appendixes B, C, and D. Other comments are presented in Appendix E.

Task analysis was conducted for the three specialty areas of orthopedics, obstetrics/newborn, and psychiatry using responses from NC officers and physicians in each specialty area. Directors and assistant directors of nursing service and nursing service department heads did not respond to as many tasks as the division officers and physicians. Write-in comments of these respondents indicated: "I am not an expert in OB;" or, "I had to ask the Labor and Delivery division officer how to evaluate these tasks." Therefore, NODAC and HSETC decided to only use the responses of physicians, nurse midwives, division officers, and staff nurses in conducting the task analysis.

Task analysis was based on the responses to three questions. The first question asked supervisors to recommend the tasks they felt nurses should perform and asked staff nurses to identify the tasks performed in their current job. The second question asked respondents to recommend the level of formal training needed for each task using the following definitions:

Familiarization - Information that includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge - Training that includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

Thirdly, we asked respondents to evaluate the performance of NC officers at facilities such as theirs, using the scale detailed below.

1 - Extremely Poor
2 - Very Poor
3 - Poor
4 - Below Average
5 - Average
6 - Above Average
7 - Good
8 - Very Good
9 - Extremely Good

For each task, we calculated the percentage of respondents who recommended training, the percentage of staff nurses performing each task, the percentage recommending each level of training and the mean performance rating of each task. The mean performance rating was obtained by summing the weighted responses (1 to 9) and dividing by the number of responses, rounding the means to the nearest whole

number. Means were rounded down if the terminal decimal was less than .5 and rounded up if the terminal decimal was greater than or equal to .5.

Figure 1 displays the decision tree used to classify the tasks into three categories: (1) the task is not recommended to be trained; (2) the task is recommended to be trained at the *Hands-On/Thorough Knowledge* level; and (3) the task is recommended to be trained at the *Familiarization* level. Appendixes B, C, and D provide recommended training levels for the task inventories in each specialty area.

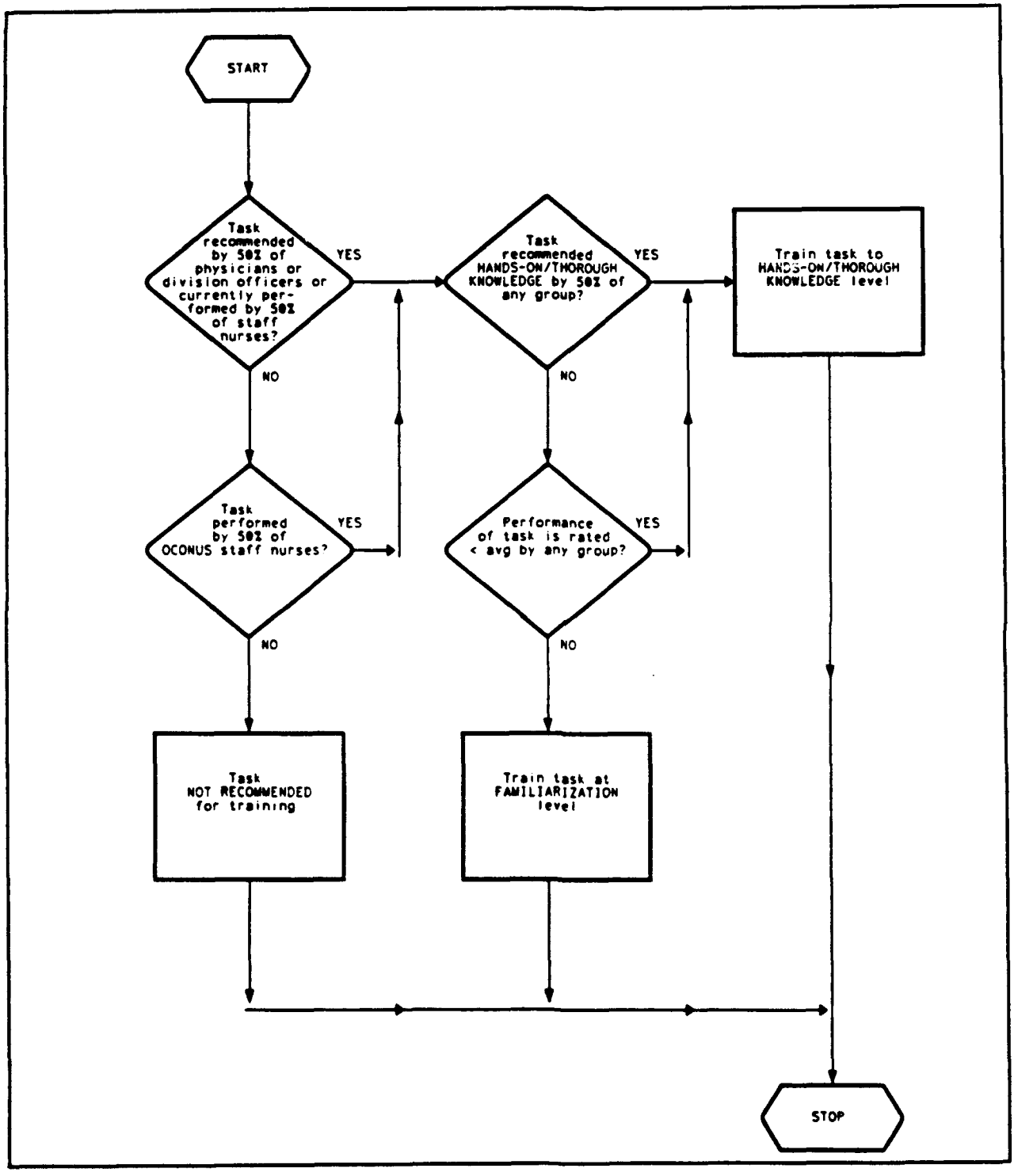

Figure 1. Decision Tree for Recommending Task Training Level

Findings

Findings are divided into two sections. First, a synopsis of the findings for the task inventories is presented. Then, findings for the training issue questions are presented[1].

Task Inventory

Orthopedic Tasks

Respondents were asked to rate 57 orthopedic tasks. Appendix B provides the results of the orthopedic task analysis. Recommendations were established using the decision tree in Figure 1, page 22. Fifty tasks were recommended to be taught at the *Hands-On/Thorough Knowledge* level. One task, *Communicate in correct orthopedic terminology* was recommended to be taught at the *Familiarization* level. The following six tasks were not recommended for training because they did not meet the criteria established in Figure 1.

Place patient in cervical halter traction after initial application

Assist physician in halo-pelvic traction procedures

Assist physician in percutaneous pinning of fractures

Maintain patient in Bryant's traction

Apply Transcutaneous Electrode Nerve Stimulation (TENS) after initial application by Physical Therapy

Monitor the effectiveness of TENS

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[1]Physicians were instructed to answer only the appropriate task inventory questions, not the training issue questions.

The majority of the orthopedic tasks had a mean performance rating from division officers, orthopedic surgeons, and staff nurses of at least Average. The following eight tasks had mean performance ratings of less than Average by orthopedic surgeons.

Apply basic knowledge of orthopedic diagnostic studies (e.g.,MRI, CAT scans)

Assist physician in applying halo apparatus

Assemble/position Zimmer frame for support of traction/suspension device

Assess and correct traction problems

Apply principles of counter traction

Demonstrate understanding of the principles of traction

Identify indications/contra-indications for cervical/lumbar traction

Differentiate between common arthritic diseases and bursitis

The following tasks were recommended for training by orthopedic surgeons but were performed by less than 50% of the staff nurses who work in orthopedics.

Assist provider in insertion of pins for skeletal traction

Assist physician in applying halo apparatus

Assemble/position Zimmer frame for support of traction/suspension device

Position/turn patient using a stryker (Foster) frame

Turn patient on circo-electric frame

Identify indications/contra-indications for cervical/lumbar traction

Fit cervical collars

The five additional tasks/knowledge/skills recommended for training by respondents are provided in Appendix B. Although the area of traction was included in the survey, it was also identified in the write-in responses by both NC officers and orthopedic surgeons.

Obstetric/Newborn Tasks

Respondents were asked to rate 99 obstetric/newborn tasks. Results of the obstetric/newborn task analysis and additional tasks recommended for training by write-in responses are in Appendix C. Recommendations were established using the decision tree in Figure 1, page 22. Ninety-four obstetric/newborn tasks were recommended to be taught at the *Hands-On/Thorough Knowledge* level. The following five obstetric/newborn tasks were not recommended for training because they did not meet the criteria established in Figure 1.

Perform ultrasound

Insert uterine catheters

Perform episiotomy

Weigh placentas

Take fetal scalp blood samples

Perform circulation nurse duties during caesarean delivery was the only task which received a mean performance rating of Below Average from any group. Obstetric/ gynecology surgeons rated this task as being performed Below Average (4.1). However, only 29 of the 81 nurses working with obstetric patients indicated that they performed this task.

The following seven tasks were recommended for training by obstetric/gynecology surgeons, nurse midwives, and division officers but were performed by less than 50% of the staff nurses who worked in obstetrics or newborn.

Initiate ritodrine procedures

Monitor ritodrine procedures

Terminate ritodrine procedures

Perform circulation nurse duties during caesarean delivery

Organize pre-natal classes

Teach family planning

Teach child development

Twelve additional tasks/knowledge/skills were recommended for training by respondents. Although the areas of fetal monitoring, sterile speculum exam, and childbirth coaching were included in the survey, they were also identified in the write-in responses by both NC officers and obstetric/gynecology surgeons.

Psychiatric Tasks

Respondents were asked to rate 94 psychiatric tasks. Results of the psychiatric task analysis are provided in Appendix D. Recommendations were established using the decision tree in Figure 1, page 22. Ninety-two tasks were recommended to be taught at the *Hands-On/Thorough Knowledge* level. The following two tasks were not recommended for training.

Score tests/questionnaires in accordance with local policy

Assist with electroconvulsive therapy in accordance with local policy

The mean performance rating for all recommended psychiatric tasks was at least Average (5) as evaluated by psychiatrists, division officers, and staff nurses. The following tasks were recommended for training by psychiatrists but were performed by less than 50% of the psychiatric staff nurses.

Participate in special ward search and report findings

Administer the Minnesota Multiphasic Personality Inventory (MMPI)

Observe/monitor patient in work therapy assignments

Administer psychological tests/questionnaires in accordance with local policy

Report/maintain documentation on patient screening

Ascertain and report patient's response to discharge and aftercare (i.e., follow up support

Assist with screening of ambulatory care psychiatric patient in accordance with local policy

Recognize and report behavior indicative of acute/delayed stress caused by combat or disasters (i.e., post traumatic stress, delayed)

Assist/conduct group/individual crisis intervention in non-ward environment (e.g., ship, line command, Marine Corps)

Participate in family advocacy programs

Participate in multi-disciplinary team conference

Position and restrain/secure patient for medical procedures (e.g., including catatonic, motorically retarded patient)

Participate in occupational therapy/work along with patient

Observe/participate in group therapy sessions and report patient's behavior
Participate in feedback sessions (e.g., post group/post community)

Conduct suicide prevention/stress management/TEAM (Treat Everyone As Me) training, and other community outreach programs

Eleven additional tasks were recommended in write-in comments. These are included with the Results of Psychiatry Task Analysis in Appendix D. Respondents also re-identified suicide assessment and prevention, psychotropic medications, group therapy, and quality assurance for training. These areas had been included in the survey.

Training Issue Questions

Nurse Corps officers were asked nine training issue questions addressing three areas: support and encouragement for specialty training; reported training levels; and patient care coverage in more than one specialty area.

Support and Encouragement of Specialty Training

For each specialty, respondents were asked to use the following six-point scale to answer four questions concerning the support and encouragement of specialty training for nurses.

0 - I Have No Basis for Determining the Extent of This Item

1 - To a Very Small Extent

2 - To a Limited Extent

3 - To a Moderate Extent

4 - To a Considerable Extent

5 - To a Great Extent

These data represent the opinions of staff nurses and supervisors regarding the extent of support and encouragement provided for nurses in facilities such as theirs for obtaining specialty training. Responses from directors and assistant directors of nursing, department heads, and division officers were grouped into one category known as supervisors. The mean responses from staff nurses and supervisors are presented. Responses are characterized in each group from Very Small Extent (1) to Great Extent (5) based on rounding means to nearest whole number. Means were rounded down if the terminal decimal was less than .5 and rounded up if the terminal decimal was greater than or equal to .5. Appendix F provides the percentage of responses to the four questions for staff nurses and supervisors.

The first question addressed the encouragement by senior management. Respondents were asked: *In facilities such as yours, to what extent are nurses encouraged by senior management to seek additional specialty training in the areas of orthopedics, obstetrics/newborn, and psychiatry?* As indicated by the mean responses

presented in Table 3, staff nurses reported the encouragement from senior management for nurses to seek additional training in orthopedics and psychiatry was Limited. Training for obstetric/newborn nurses appeared to receive Moderate encouragement, as reported by staff nurses. Supervisors indicated that nurses were encouraged to seek additional training To a Considerable Extent in Obstetrics/Newborn, To a Moderate Extent in psychiatry and To a Limited Extent in orthopedics.

Table 3

The Extent Nurses are Encouraged by Senior Management to Seek Additional Specialty Training: Mean Response

Specialty Area	Mean Response: Staff Nurses (n=214)	Mean Response: Supervisors (n=101)
Orthopedics	Limited (n=100)	Limited (n=62)
Obstetrics/Newborn	Moderate (n=112)	Considerable (n=70)
Psychiatry	Limited (n=67)	Moderate (n=65)

RESPONSE SCALE		
1 - To a very small extent	3 - To a moderate extent	5 - To a great extent
2 - To a limited extent	4 - To a considerable extent	

Note. Appendix F, Tables 13 and 14, provides the percentage of responses for staff nurses and supervisors.

Some of the write-in comments added substance to these findings.

I feel that, for the most part, nurses at this facility are not supported on the Psychiatric unit. They are sent with no training. There is not time to teach new staff how to run groups, stop disruptive behavior or staff splitting (Staff Nurse Psychiatry, 98 Plus Bed Size-Hospital CONUS).

> The single biggest factor in the retention of obstetricians as it relates to nursing is the excessive turnover rate of nurses. Nurses come to L&D [Labor and Delivery] with no experience, receive OJT, and transfer after 12-18 months when they are finally trained. The second largest factor is lack of support from senior nurses and a commitment to practicing 1990s OB [Obstetrical] nursing with resultant high medical/legal exposure (Obstetric/Gynecology Surgeon Family Practice Hospital CONUS).

The second question addressed the extent that financial resources are available for nurses to obtain specialty training. Respondents were asked: *In facilities such as yours, to what extent are financial resources available for nurses to obtain specialty training when needed to work in orthopedics, obstetrics/newborn, or psychiatry?* Table 4 shows staff nurses reported financial resources were Limited. Supervisors responded that financial resources were available To a Moderate Extent for all three of the specialties.

Table 4

The Extent Financial Resources are Available for Nurses to Obtain Specialty Training: Mean Response

Specialty Area	Mean Response: Staff Nurses (n=214)	Mean Response: Supervisors (n=101)
Orthopedics	Limited (n=86)	Moderate (n=59)
Obstetrics/Newborn	Limited (n=104)	Moderate (n=65)
Psychiatry	Limited (n=62)	Moderate (n=61)

RESPONSE SCALE		
1 - To a very small extent	3 - To a moderate extent	5 - To a great extent
2 - To a limited extent	4 - To a considerable extent	

Note. Appendix F, Tables 15 and 16, provides the percentage of responses for staff nurses and supervisors.

These findings were supported by some of the write-in comments.

> This hospital cross-trains its own staff on a one to one basis. The area resources and funding do not provide extensive outside training. Even in small CONUS hospitals we were expected to pay our own way on our own time to attend training or seminars (Staff Nurse Less Than 50 Bed-Size Hospital OCONUS).

> Average 40 deliveries per month, yet in the past 2 years no NC officers with OB/Newborn skills or experience have been assigned to our facility. We have the capability of putting in a fetal monitoring course, but it is not cost effective because we do not have enough staff to cover workload and send staff to class. All didactic training has to be TAD. Frequently there is cancellation of intended courses at other MTFs (medical treatment facilities). All training is OJT but frequently interrupted because the orienting nurse has to go back to another area to cover (Assistant Director of Nursing Service Less Than 50 Bed-Size Hospital CONUS).

The third question addressed the availability of manpower resources. Nurse Corps officers were asked: *In facilities such as yours, to what extent are manpower resources (i.e., flexible scheduling or dedicated time for training) available to permit nurses to seek additional specialty training in orthopedics, obstetrics/newborn, or psychiatry?* Table 5 presents the findings for this question. Staff nurses reported the availability of manpower resources to permit them to obtain the training in any of the specialties was Limited. Supervisors indicated manpower resources were available To a Moderate Extent in all three specialties.

Table 5

The Extent Manpower Resources are Available to Permit Nurses to Seek Additional Specialty Training: Mean Response

	Mean Response	
Specialty Area	Staff Nurses (n=214)	Supervisors (n=101)
Orthopedics	Limited (n=99)	Moderate (n=63)
Obstetrics/Newborn	Limited (n=114)	Moderate (n=67)
Psychiatry	Limited (n=72)	Moderate (n=60)

RESPONSE SCALE		
1 - To a very small extent	3 - To a moderate extent	5 - To a great extent
2 - To a limited extent	4 - To a considerable extent	

Note. Appendix F, Tables 17 and 18, provides the percentage of responses for staff nurses and supervisors.

Write-in comments reported the difficulty of allowing the nurse to have time off for additional training.

> I have one opportunity one time a year for two weeks to send one nurse into the local hospital to get some OJT in obstetrics and newborns (Director of Nursing Service Less Than 50 Bed-Size Hospital OCONUS).

I had to ask the CO to close labor and delivery, postpartum and newborn nursery for 3 weeks to send our nurses to [98 Plus Bed-Size Hospital] for training. When these nurses returned, their skills were not only outstanding, but they said they felt so much more confident, because they had the opportunity to care for a large number and variety of patients (Director of Nursing Service 50-98 Bed-Size Hospital CONUS).

If training was available we are unable to support it due to staffing shortfalls. Plus most of our TAD money goes to bring TAD nurses to fill empty billets. Orthopedics is a major part of our workload and orthopedic training is scarce and under supported (Assistant Director of Nursing Service Less Than 50 Bed-Size Hospital CONUS).

The fourth question dealt with the extent that nurses themselves seek additional training. Respondents were asked: *In facilities such as yours, to what extent do nurses seek specialty training in preparation for current or projected reassignment in orthopedics, obstetrics/newborn or psychiatry?* Table 6 presents the mean responses to this question. Staff nurses answered this question for all three specialties as Limited. Supervisors rated this question as Limited for orthopedics and psychiatry and Moderate for obstetrics/newborn.

Table 6

The Extent Nurses Seek Specialty Training in Preparation for Current or Projected Reassignments: Mean Response

Specialty Area	Mean Response: Staff Nurses (n=214)	Mean Response: Supervisors (n=101)
Orthopedics	Limited (n=80)	Limited (n=57)
Obstetrics/Newborn	Limited (n=101)	Moderate (n=60)
Psychiatry	Limited (n=60)	Limited (n=53)

RESPONSE SCALE		
1 - To a very small extent	3 - To a moderate extent	5 - To a great extent
2 - To a limited extent	4 - To a considerable extent	

Note. Appendix F, Tables 19 and 20, provides the percentage of responses for staff nurses and supervisors.

Write-in comments offered two sides to the perception of whether nurses seek additional training when they are assigned to a specialty area.

> I have served in all types of facilities and am impressed that nurses try very hard to meet needs, but resources of funding and command support have been financially inadequate and subject to physician involvement (Obstetric/Gynecology Surgeon Family Practice Hospital).

The training received by the nurses assigned to the psychiatric ward is minimal and even the charge nurses have limited experience. The bulk falls on the psychiatric technicians who are qualified to impart information on safety issues such as restraint techniques and maintain a locked ward but are not qualified to instruct RNs in the therapeutic one-to-one plans, group therapy, therapeutic milieu, unconditional positive regard, etc. The result of this form of training is a passive RN, who lets the psychiatric technician dictate milieu and therapeutic interventions (Division Officer 50-98 Bed-Size Hospital OCONUS).

I find ward nurses to be practically inept with regard to N/V (neuro-vascular) assessment and general care of orthopedic patients. They seem to rely on the therapists and MDs. I don't think they have enough training or interest in orthopedic care (Orthopedic Surgeon 98 Plus Bed-Size Hospital).

We have a level II [Newborn Nursery]. Need more [Neonatal Advanced Life Support (NALS)] courses offered, so all nurses are NALS prepared. Only one nurse is scheduled on nights. I would like more TAD for conferences, etc., for fetal monitoring (Staff Nurse Family Practice Hospital).

It is virtually impossible to go to inservice for further training. The reason is always "staffing won't permit it" (Staff Nurse Family Practice Hospital).

Training Levels Reported

The following findings reflect the number of weeks of formal training in each specialty and the percentage of division officers and staff nurses who held certifications and master's degrees in the specialties.

Weeks of Formal Training.

Respondents were asked to record the number of cumulative weeks of formal training they had received in orthopedics, obstetrics, newborn, and psychiatry. They were instructed to consider technician-level training in physical therapy, orthopedics or psychiatry, or obstetrical licensed practical nurse training. Table 7 presents the average number of cumulative weeks for each specialty for division officers and staff nurses assigned to each specialty area. Nurse Corps officers who had indicated that they had

master's degrees were not included in the calculation of the average number of weeks of formal training for NC officers in each specialty. These results are provided in Table 9. Less than 50% of the staff nurses and division officers working in orthopedics indicated that they had any training in these specialty areas. The average number of weeks of training for orthopedic division officers was three; for staff nurses it was five. Division officers in obstetrics had, on average, two weeks of training and staff nurses had five weeks. Sixty-four percent of the division officers and 62% of the staff nurses in the newborn area responded they had formal training. The average for division officers was three weeks and the average for staff nurses was six weeks. Ninety percent of division officers and 46% of the staff nurses in psychiatry indicated that they had some weeks of formal training. The average number of weeks for division officers was 12[2] and staff nurses six.

[2]Does not include the respondent who indicated 99 weeks, since this individual was so atypical of the other respondents. Inclusion would have skewed the data.

Table 7

Average Number of Cumulative Weeks of Formal Training in Specialty Areas for Division Officers and Staff Nurses

Job Title	Response: Average # of Cumulative Weeks of Training	Response: Percentage Who Reported Formal Training
	Orthopedics	
Division Officer (n=12)	3 weeks	33
Staff Nurse (n=93)	5 weeks	43
	Obstetrics	
Division Officer (n=13)	2 weeks	38
Staff Nurse (n=81)	5 weeks	60
	Newborn	
Division Officer (n=11)	3 weeks	64
Staff Nurse (n=65)	6 weeks	62
	Psychiatry	
Division Officer (n=10)	12 weeks	90
Staff Nurse (n=53)	6 weeks	46

The following write-in comments express the varying amounts of weeks of training.

> Typically, a nurse pursuing overseas orders will spend 2 weeks on an active labor deck before being [transferred] to a new command. This is not enough time to feel comfortable with normal Labor and Delivery procedures. Four weeks may be a more realistic period of time to devote to training (Staff nurse 98 Plus Bed-Size Hospital OCONUS).

> I have no L&D/OB training. All experience is from OJT training since arriving here. Would be nice to either send experienced RN's (OB/L&D) here or send nurses to a 4 week training at a larger duty station prior to arriving here (Staff Nurse Less Than 50 Bed-Size Hospital).

> Of the 20 or so nurses I worked with only 2 had Psychiatric training (Staff Nurse 98 Plus Bed-Size Hospital CONUS).

> I feel that for the most part, nurses at this facility are not supported on the psychiatric unit. They are sent here with no training (Staff Nurse 98 Plus Bed-Size Hospital).

Certifications and/or Graduate Levels of Education.

Table 8 presents the percentage of staff nurses and division officers who possessed certifications. The requirements for certification by a national specialty organization include a specified length of experience and a qualification test. Certification by a national specialty organization implies the NC officer has devoted many off-duty hours to studying and learning in order to pass the examination.[3] Orthopedics did not have any division officers certified by their national specialty organization. Eleven percent of the obstetric staff nurses and 9% of the newborn staff nurses possessed Nurses Association American College of Obstetrics and Gynecology

[3]HSETC reimburses NC officers for the examination fee

(NAACOG) Inpatient Obstetrics certification. Twenty-nine percent of the obstetric division officers and 25% of the newborn division officers possessed NAACOG Inpatient Obstetrics certification. None of the obstetric or newborn division officers or staff nurses possessed the American Nurses Association certification in Perinatal Nursing. Fifty-three percent of the obstetric staff nurses and 51% of the newborn nurses were certified in Neonatal Advanced Life Support (NALS). Twenty-nine percent of the obstetric division officers and 42% of the newborn division officers had NALS certification. The requirement for NALS or the Neonatal Resuscitation Course (NRC) was only recently established for medical department personnel caring for newborns in August 1991 (BUMED 1991).

Table 8

Percentage of Staff Nurses and Division Officers Who Possess Certification in the Specialty Areas

Certification	Response: Staff Nurses	Response: Division Officers
	Orthopedics	
	(n= 93)	(n = 12)
Certification by National Association of Orthopaedic Nurses (NAON)	2	0
	Obstetrics/Newborn[a]	
	(n = 81/65)	(n = 14/12)
Nurses Association American College of Obstetrics and Gynecology (NAACOG) Inpatient Obstetrics	11/09	29/25
American Nurses Association (ANA) Perinatal Nursing	0/0	0/0
American Heart Association Neonatal Advanced Life Support (NALS) Certification	53/51	29/42
	Psychiatry	
	(n=53)	(n=12)
American Nurses Association (ANA) Mental Health Nurse	2	33
American Nurses Association (ANA) Mental Health Clinical Nurse Specialist	0	8

[a]Responses sorted and reported for each area due to the overlap of nurses assigned to more than one area

Many respondents wrote comments concerning NALS or NRC certification and the need for certification in fetal monitoring for nurses who are assigned to obstetrics/newborn. Typical remarks were:

> A year after I was at this job, I received a NALS class. This was what I should have learned before working in the nursery (Staff Nurse OCONUS Hospital).
>
> Currently we have no formally trained OBGYN or L&D nurses. None have attended a formal fetal monitoring course. Nearest civilian facility doing OB is 80 miles away (Nursing Service Department Head Less Than 50 Bed-Size Hospital).
>
> All nurses assigned to Labor and Delivery should be required to pass a fetal monitoring course (Obstetric/Gynecology Surgeon OCONUS Hospital).

Table 9 displays the percentage of staff nurses and division officers in each area who possess a master's degree in a specialty area. Note that the numbers at the type of facilities surveyed were very low. A higher proportion of psychiatric nurses possessed both certifications and master's degrees than for the other specialty areas.

Table 9

Percentage of Staff Nurses and Division Officers Who Possess Master's Degrees in the Specialty Areas

Degree	Response: Staff Nurses	Response: Division Officers
	Orthopedics	
	(n= 93)	(n = 12)
Master's In Medical-Surgical Nursing with Orthopedic Emphasis	2	0
	Obstetrics/Newborn[a]	
	(n = 81/65)	(n = 14/12)
Master's in Maternal Child Health Nursing	0/0	7/8
	Psychiatry	
	(n=53)	(n = 12)
Master's in Psychiatric Nursing	2	16

[a]Responses sorted and reported for each area due to the overlap of nurses assigned to more than one area

Patient Care Coverage in More Than One Specialty Area

Health Sciences Education and Training Command (HSETC) was interested in the numbers of NC officers assigned to care for more than one type of specialty patient in these three areas. Findings are presented for NC officers who stood the Nurse of the Day (NOD) duty and NC officers who provided after-hours patient coverage.

Nurse of the Day (NOD) Duties.

Respondents were asked to identify the areas in which they performed NOD duties. Sixty-nine staff nurses and 32 division officers indicated that they had NOD duty in at least one of the specialty areas. Nurse of the Day duties consist of providing after-hours nursing supervision for the hospital. This watch-standing or duty is normally assigned to NC officers in the ranks of LT (O-3) and above. Responsibilities include representing the Director of Nursing Service, arranging for staffing coverage, and ensuring safe quality patient care.

Table 10 presents the percentage of staff nurses and division officers who stood NOD duty in each of the specialty areas. Forty-two percent of NOD watch-standers who usually work in orthopedics performed the NOD duty in obstetrics/newborn or psychiatry. Forty percent of the NOD watch-standers assigned to obstetrics/newborn indicated they provided NOD coverage for orthopedics or psychiatry. Psychiatry had the largest percentage of its staff nurses and division officers providing NOD coverage in specialty areas outside of their own specialty area. Sixty-nine percent and 50% of these NC officers stood the NOD in orthopedics and obstetric/newborn respectively.

Table 10

Percentage of Staff Nurses and Division Officers Who had Nurse of the Day (NOD) Duties in Specialty Areas

Routine Specialty Area Assignment	NOD Duty Assignment		
	NOD Duty in Orthopedics	NOD Duty in Obstetrics/ Newborn	NOD Duty in Psychiatry
Orthopedics (n = 38)	87	42	42
Obstetrics/Newborn (n = 50)	40	94	40
Psychiatry (n = 26)	69	50	89

One write-in comment expressed concern over the NOD concept and working outside of a specialty:

> The Nurse of the Day concept is becoming dangerous since so many fields are quite technical and no one can know everything about all specialties any more. What's the use of becoming certified in mental health, if you are assigned to an orthopedic ward and do NOD in a hospital with no psychiatric services (Nursing Service Department Head 98 Plus Bed-Size Hospital).

After-Hours Coverage.

Some NC officers were required to provide after-hours staffing coverage for areas outside their usual work place. The respondents were asked to indicate, for each of the specialty areas, if they provided after-hours coverage in a specialty area. They were instructed to answer only if the area was not in the specialty area where they were usually assigned. Table 11 presents the percentage of staff nurses and division officers working in the specialty areas who provided after-hours coverage.

Twenty-five percent of the staff nurses indicated they provided after-hours coverage for at least one specialty area outside of their usual specialty assignment. Thirty-one percent of the division officers provide after-hours coverage in at least one specialty area in addition to their specialty area.

Although the findings in Table 11 are very small, this might be explained by the proportion of these NC officers who were already assigned to two or more areas. Seventy-five of the 192 staff nurses indicated that they worked in more than one specialty area. Of this number, 51 were assigned to hospitals with less than 98 beds (Table 12).

Table 11

Percentage of Staff Nurses and Division Officers Who Provided After-Hours Coverage in Areas Not of their Specialty

	Job Title	
Number of Areas	Staff Nurse (n =192)	Division Officer (n=36)
One Area	14	8
Two Areas	7	17
Three Areas	4	6
Total	25	31

Table 12

Number of Staff Nurses Assigned to Specialty Areas

Number of Areas	Size of Facility: Less Than 98 Bed-Size Hospitals	Size of Facility: 98 Plus Bed-Size and Family Practice Hospital	Total
One Area	*19*	*98*	*117*
Two or More Areas	*51*	*24*	*75*
Total	*70*	*122*	*192*

Some of the write-in comments indicated the multi-service environment of the wards:

> Nurse Corps officers and civilian nurses assigned are required to be flexible; we have one inpatient ward which covers all specialty areas (Less Than 50 Bed-Size Hospital Director of Nursing Service).

> Psychiatric patients are kept on a general ward and receive treatment in mental health clinics. Ward setting is more of a secure room with staff to provide one-on-one watch (Assistant Director Of Nursing Service Less Than 50 Bed-Size Hospital OCONUS).

We have one ward to care for medical, surgical, and pediatric as well as patients in the four categories being examined (Director of Nursing Service Less Than 50 Bed-Size Hospital).

In our OCONUS hospital the NC do the best they can, but none have any psychiatric training and the only admissions are for acute, dangerous patients. There are no psychiatric beds per se, no isolation or quiet rooms, and patients are placed on one to one watch or in restraints, if needed (Psychiatrist Less than 50 Bed-Size OCONUS).

Summary Of Findings

Fifty orthopedic tasks, 94 obstetric/newborn tasks, and 92 psychiatric tasks were recommended for training at the *Hands-On/Thorough Knowledge* level. One orthopedic task was recommended to be taught at the *Familiarization* level. Staff nurses and division officers gave all the recommended tasks a mean task performance rating of at least Average (5). Only nine tasks, eight in orthopedics and one in obstetrics, were rated below average by physicians. Twenty-eight tasks/knowledge/or skills, five orthopedic, 12 obstetric/newborn, and 11 psychiatric were recommended for additional training by write-in comments. Although included in the survey, traction skills, fetal monitoring, childbirth coaching, sterile speculum exams, suicide assessment and prevention, psychotropic medications, group therapy, and quality assurance were also re-emphasized in the write-in responses.

Staff nurses said they were encouraged to seek additional training in obstetrics/newborn to a moderate extent and in orthopedics/psychiatry to a limited extent. Staff nurses reported the availability of financial and manpower resource support for training in all three specialties was limited. Supervisors indicated that

encouragement for training given to staff nurses by senior management was limited for orthopedics, moderate for psychiatry, and considerable for obstetrics/newborn. Supervisors reported financial and manpower resources were available to a moderate extent for all three specialties.

Both groups indicated the extent that nurses sought additional training in preparation for current or projected reassignments in orthopedics and psychiatry was limited. Staff nurses reported that nurses sought specialty training in obstetrics/ newborn to a limited extent, while supervisors said nurses sought specialty training in obstetrics/newborn to a moderate extent.

Less than 50% of the staff nurses and division officers working in orthopedics indicated that they had any formal training. The average number of weeks of training for orthopedic staff nurses was five and division officers three. Division officers in obstetrics had, on average, two weeks of training, and staff nurses had five weeks. In psychiatry, 90% of division officers reported having received some formal training, with 12 weeks being the average reported. Staff nurses in psychiatry averaged six weeks of formal training.

Overall, the certifications from the national organizations such as the ANA and the specialty organizations had very low representation. Orthopedics did not have any division officers certified by their national specialty organization. Twenty-nine percent of the obstetric division officers and 25% of the newborn division officers were certified by NAACOG. Eleven percent of the obstetric staff nurses and 9% of the newborn staff nurses were certified by NAACOG. The obstetric/newborn specialty did not have any staff nurses or division officers certified by the American Nurses Association in Perinatal

Nursing. Psychiatry had 2% of their staff nurses and 33% of their division officers certified as ANA Mental Health Nurse. Eight percent of psychiatry division officers and no staff nurses were certified as ANA Mental Health Clinical Nurse Specialist.

Fifty-three percent of the obstetric staff nurses and 51% of the newborn nurses were certified in NALS. Twenty-nine percent of the obstetric division officers and 42% of the newborn division officers had NALS certification.

Relatively few respondents reported completion of master's degrees in the specialty areas studied. In orthopedics, only 2% of staff nurses and no division officers reported possessing master's degrees with orthopedic emphasis. Seven percent of obstetric division officers, 8% of newborn division officers and no staff nurses in these areas reported completion of master's degrees in maternal child health nursing. In psychiatry, 2% of staff nurses and 16% of the division officers had master's degrees in psychiatric nursing.

At least 40% of the NC officers assigned to NOD duty stand this watch in specialty areas other than their own. Twenty-five percent of the staff nurses indicated they provided after-hours coverage for at least one specialty area outside of their usual specialty assignment. Thirty-one percent of the division officers provided after-hours coverage in at least one specialty area in addition to their specialty area. Seventy-three percent of the staff nurses assigned to hospitals with less than 98 beds provided care to at least two types of specialty patients.

Conclusions and Recommendations

Conclusions

The finding that only one task was recommended to be trained at the *Familiarization* level may be explained by the design of the TIS model. The TIS was originally designed for the hospital corpsman technicians. Nurse Corps officers are expected to perform tasks at a higher level than hospital corpsmen. The fact that so many tasks were recommended for training validates BUMED's concern for identifying methodologies for providing entry-level training for nurses corps officers in these specialties. The tasks/knowledge/skills included in the write-in comments substantiates this concern for training. The additional tasks, noted in the write-in comments, demonstrates clearly the strong interest of survey participants in obtaining this training for NC officers. The repetition of survey tasks in the write-in comments also suggests that these tasks be a current training priority.

The opinions of staff nurses and supervisors that encouragement and support for obtaining this specialty training were available from a limited to moderate extent suggest that the facilities may not be able to provide the specialty training with the existing manpower and financial resources. Some of the write-in comments, although only anecdotal, seem to confirm the difficulty of providing the specialty training needed by these NC officers.

The reports from staff nurses and supervisors that nurses only seek specialty training to a limited or moderate extent might be explained by the findings in the area of support for financial or manpower resources. Nurses may not be seeking additional

training because they find it too difficult to obtain. Another explanation is that the NC officer may not be interested in assignment to the specialty.

Although the percentages of NC officers with large numbers of weeks of formal training or certification in the national specialty organizations or masters' degrees in the specialties cannot be applied to the total NC population, these findings do give an idea of the limited number of potential expert resources available in small and medium-sized hospitals. Lack of resources could make it difficult for these hospitals to implement their own on-the-job training (OJT) programs. When this is viewed in conjunction with the anticipation that, by September 1993, a third of the NC will have less than 3 years of active duty experience (BUMED 1992 p. 13), it suggests that facilities will face increasing difficulties.

Additionally, it is important to note that despite the limited number of weeks of formal training possessed by these NC officers, only a few tasks had a mean performance rating of below average. However, the traction tasks which were rated below average by orthopedic surgeons may need further evaluation by individual medical treatment facilities. The dependence on the orthopedic technician and limited opportunity to perform these tasks implied by write-in comments, offer a partial explanation of the below-average performance.

The finding that most of the staff nurses assigned to small hospitals provided care to at least two types specialty patients, indicates a need for cross-training in all types of specialty areas. The percentage of staff nurses and division officers who provided after-hours coverage in areas not in their specialty and the percentage of NOD watch-standers who supervise more than one specialty area reinforce the need for this type of

training. As the Navy downsizes and medical treatment facilities combine inpatient units to maximize manpower resources, the need to provide well-prepared NC officers to diverse specialty areas will increase.

When both quantitative and anecdotal responses to this survey are viewed together, a picture emerges which reflects the dilemma faced in many communities throughout the Navy. Diversity of needs does not decrease when an organization grows smaller. Therefore, maintaining the flexibility to respond to this diversity places a great premium on broadly experienced generalists. At the same time, training dollars and manpower shortages place an equal premium on optimizing training investment through specialization, rather than generalization. The Navy medical department faces the challenge of balancing the complex patient care demands for specialization with the necessity for training clinically flexible NC officers who can be assigned to small, isolated, and overseas facilities.

Recommendations

- Use findings to develop curricula that support entry level training for NC officers in orthopedics, obstetrics/newborn, and psychiatry.

- Target the scope of training that will prepare NC officers for the number of unique specialties required for projected assignments.

- Circulate this report to medical treatment facilities and training organizations to supplement existing orientation and training programs.

References

Bureau of Medicine and Surgery. (1991, June 4). Issue Paper *Introductory Specialty Inservice for Nurses*. (Available from BUMED (Code 5), Washington, DC).

Bureau of Medicine and Surgery. (1991, August 27). Instruction 1500.15 *Resuscitation Training*. (Available from BUMED (Code 5), Washington, DC).

Department of the Navy. (1992, February 10) *Department of the Navy Vision, Guiding Principles and Strategic Goals*. Washington, DC: Department of the Navy.

Director, Navy Nurse Corps. (1992, January) *Nurse Corps Information Update.* Bureau of Medicine and Surgery, Washington, DC: Department of the Navy.

Gottesman, Alexander M. (1985, May). Cyclical curriculum review - a systems approach. *Journal of Systems Management,* 30-31.

Appendix A: Medical Treatment Facilities

	Specialty Areas		
	Orthopedics	Obstetrics/Newborn	Psychiatry
FAMILY PRACTICE HOSPITALS			
Camp Pendleton Naval Hospital	x	x	x
Charleston Naval Hospital	x	x	x
Jacksonville Naval Hospital	x	x	x
Pensacola Naval Hospital	x	x	x
98 PLUS BED-SIZE HOSPITALS			
Bremerton Naval Hospital	x	x	x
Camp Lejeune Naval Hospital	x	x	x
Great Lakes Naval Hospital	x		x
Long Beach Naval Hospital	x		x
Orlando Naval Hospital	x	x	x
Okinawa Naval Hospital (OCONUS)	x	x	x
Yokosuka Naval Hospital (OCONUS)	x	x	x
50 TO 98 BED-SIZE HOSPITALS			
Beaufort Naval Hospital	x	x	
Millington Naval Hospital	x	x	x
Guam Naval Hospital (OCONUS)	x	x	x
Rota Naval Hospital (OCONUS)	x	x	x
Subic Bay Naval Hospital (OCONUS)	x	x	x
LESS THAN 50 BED-SIZE HOSPITALS			
Cherry Point Naval Hospital		x	
Groton Naval Hospital	x		
Oak Harbor Naval Hospital	x	x	
29 Palms Naval Hospital	x	x	
Guantanamo Cuba Naval Hospital (OCONUS)	x	x	x
Adak Naval Hospital (OCONUS)	x	x	x
Keflavik Naval Hospital (OCONUS)	x	x	x
Naples Naval Hospital (OCONUS)	x	x	x
Roosevelt Roads Naval Hospital (OCONUS)	x	x	

Appendix B: Results of Orthopedic Task Analysis and Additional Training Comments

I. Orthopedic Task Inventory - Recommended training levels were established using the Decision Tree in Figure 1, page 22.

II. Additional Training for Orthopedics - These were obtained from write-in comments from survey participants.

III. Quoted Comments: Additional Training Needed - Orthopedics: Listing of comments, sorted by facility size and job title.

B - I. ORTHOPEDICS TASK INVENTORY

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
BASIC KNOWLEDGE			
1. Communicate in correct orthopedic terminology		X	
2. Perform basic musculoskeletal assessment for common upper and lower extremity injuries	X		
3. Observe/report patient's range of motion	X		
4. Provide psychological aspects of orthopedic care	X		
5. Apply basic knowledge of orthopedic diagnostic studies (e.g., MRI, CAT scans)	X		
6. Apply basic knowledge of orthopedic diagnostic lab results (e.g., ANA, sedimentation rates)	X		
7. Assist provider in collection of skin/bone samples for laboratory analysis	X		
COMPLICATIONS			
8. Recognize signs and symptoms of compartment syndrome	X		
9. Initiate treatment for compartment syndrome	X		
10. Assist in measurement of compartment syndrome	X		
THERAPEUTIC MODALITY			
11. Assist provider in insertion of pins for skeletal traction	X[1]		
12. Apply ace wrap to injured ankle	X		
13. Apply sling/swath	X		
14. Apply knee immobilizer	X		
15. Remove knee immobilizer	X		
16. Assist physician in applying halo apparatus	X[1]		
17. Apply and adjust Continuous Passive Motion (CPM) equipment	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
18. Provide care for the patient with external/fixation devices	X		
19. Incorporate preventive measures to avoid skin irritation when applying traction	X		
20. Apply/adjust proper weight for traction as ordered by provider	X		
21. Place patient in cervical halter traction after initial application			X
22. Assist physician in halo-pelvic traction procedures			X
23. Assist physician in percutaneous pinning of fractures			X
24. Assemble/position Zimmer frame for support of traction/suspension device	X[1]		
25. Set up trapeze apparatus	X		
26. Position/turn patient using a stryker (Foster) frame	X[1]		
27. Assess and correct traction problems	X		
28. Apply principles of counter traction	X		
29. Perform pin/tong care traction	X		
30. Turn patient on circo-electric frame	X[1]		
31. Set/adjust stockinette sling	X		
32. Apply bulky hand dressing	X		
33. Apply lumbar-sacral support (corset) after initial application	X		
34. Apply figure 8 (clavicle strap)	X		
35. Instruct patient in prevention of cast complications	X		
36. Assess neuro/circ status after cast application	X		
37. Maintain patient in bucks (bilateral) traction (using skin or prefab devices)	X		
38. Maintain patient in Bryant's traction			X
39. Identify cast complications and appropriate corrected actions	X		
40. Fit patient in the use of crutches/canes/walkers	X		
41. Assist patients in use of walking devices (e.g., crutches/walkers)	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
42. Demonstrate understanding of the principles of traction	X		
43. Identify indications/contra-indications for cervical/lumbar traction	X[1]		
44. Fit cervical collars	X[1]		
45. Apply Transcutaneous Electrode Nerve Stimulation (TENS) after initial application by Physical Therapy			X
46. Monitor effectiveness of TENS			X
47. Teach patient implications of chronic osteomyelitis	X		
48. Teach patient implications of lower extremity injuries/surgeries on activities of daily living	X		
49. Teach patient implications of upper extremity injuries/surgeries on activities of daily living	X		
50. Teach patient implications of neck and back injuries/surgeries on activities of daily living	X		
Common Orthopedic Disorders			
51. Differentiate between common arthritic diseases and bursitis	X		
52. Identify common congenital abnormalities	X		
53. Identify common growth abnormalities	X		
54. State cause and treatment for osteoporosis	X		
55. Identify common muscle disorders	X		
56. Identify common orthopedic anti-inflammatory and analgesic drugs	X		
57. Identify common orthopedic injectables	X		

[1]Performed by less than 50% of staff nurses

B - II. ADDITIONAL TRAINING FOR ORTHOPEDICS

(Recommendations from survey participants)

BASIC KNOWLEDGE

-Paperwork requirements in clinic, operating rooms, and ward, and how they are related

THERAPEUTIC MODALITY

-Orthopedic traction principles*
-Instrumentation modalities in clinical setting
-Post-op care

COMMON ORTHOPEDIC DISORDERS

-Orthopedic injuries
-Orthopedic diseases

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* Included in survey

B - III. Quoted Comments: Additional Training Needed - Orthopedics

FAMILY PRACTICE HOSPITAL	
Director of Nursing Service	Only our tertiary medical centers have dedicated orthopedic wards - in other facilities, nurses will not be able to specialize (i.e., they will need to take care of a variety of medical/surgery patients in addition to orthopedic patients). Therefore, the best alternative is to send one or two nurses annually to "short courses" or "updates" (2-3 days) and make them "collateral duty orthopedic experts."
Orthopedic Surgeon	Current NC (and this is not meant to be a comment on all NC - just the ones that led to this comment) needs to have more pride and preparation. Prepare for an OR case by reading about it and knowing what equipment will be needed and where it is kept. Good nurses (I trained civilian) handed me a piece of equipment as I needed it - they made it their business to be familiar with procedures.
Orthopedic Surgeon	OJT on orthopedic traction principles, instrumentation modalities in clinical setting and orthopedic injuries and diseases.
Staff Nurse	[Training] needed - area of traction - monitoring and identifying problems.
98 PLUS BED-SIZE HOSPITAL	
Director of Nursing Service	Orthopedics - every junior nurse should rotate to orthopedics even if for 3 months. Generally, orthopedics is big business in overseas facilities.
Orthopedic Surgeon (OCONUS)	Traction concepts. Understanding of orthopedic procedures.
Orthopedic Surgeon	Inservice for the ward staff, conducted by the orthopedic technicians, has helped BUT with the ever presence of the "ortho tech," it quickly becomes more time efficient to just "page" the tech to perform the task at hand.
50-98 BED-SIZE HOSPITAL	
Orthopedic Surgeon	All orthopedic nurses (OR and Floor) should be required to obtain NAON certification (which the Navy should pay for, of course).

BELOW 50 BED-SIZE HOSPITAL	
Division Officer	Orthopedics is a rapidly changing area. Periodic TAD at larger facilities to seek/learn new equipment and techniques would be extremely beneficial to those of us at smaller facilities.
Division Officer	Though TAD and additional training is encouraged, there does not appear to be enough in-house, on-going training available that would better utilize staff, save money, and make teaching more available to staff members. With a majority of the staff nurses standing onboard duties and rotating shifts, TAD scheduling and financial constraints may often be limiting factors. This facility sees enough orthopedic patients for the command to provide classes for the nursing and corps staff.
Staff Nurse	Need basic knowledge re: Post op care of the orthopedic patients.
Staff Nurse	The only realistic way to train nurse corps officers in these specialty areas is to orient someone to these fields and learn by doing or by experience. My orthopedic training occurred prior to joining the Navy when working on a 30 bed orthopedic unit in a major teaching facility. I often utilized training that I learned, 10 years ago and apply it to my current practice.
LOCATION MISSING	
Job Title Missing	Substantial training and assessment skills could be obtained at this facility by rotating ward nurses through the orthopedic clinic to work alongside the physicians for a period of time. This would enable them to utilize many of these skills on the ward setting.
Job Title Missing	While nurses are generally deficient in various aspects of care of orthopedic surgery patients, the area of greatest concern is one of general patient care. Actual patient care is delegated to neophyte nursing personnel (HA/HN) without adequate supervision. A greater knowledge of the orthopedic surgical inpatient would be desirable, but I would settle for better general patient care by nursing personnel - participation of nurses, particularly. Streamlining paper shuffling requirements of nurses (nursing diagnosis, etc.) would facilitate return to patient care. Corpsmen, not nurses, assist physicians, directly monitor patients. Currently survey does not provide performance category for this.

Appendix C: Results of Obstetric/Newborn Task Analysis and Additional Training Comments

I. Obstetric/Newborn Task Inventory - Recommended training levels were established using the Decision Tree in Figure 1, page 22.

II. Additional Training for Obstetrics/Newborn - These were obtained from write-in comments from survey participants.

III. Quoted Comments: Additional Training Needed - Obstetrics/Newborn: Listing of comments, sorted by facility size and job title.

C - I. OBSTETRIC/NEWBORN TASK INVENTORY

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
ANTEPARTUM			
1. Apply knowledge of the anatomic changes associated with pregnancy	X		
2. Apply knowledge of fetal/placental growth development	X		
3. Apply knowledge of life styles/nutrition/drugs on the fetus	X		
4. Apply knowledge of complications/interventions of pregnancy	X		
5. Assist provider with amniocentesis	X		
6. Prepare patient for ultrasound	X		
7. Assist provider with ultrasound	X		
8. Perform ultrasound			X
9. Perform toxemia checks	X		
10. Conduct nipple stimulation contraction test	X		
11. Conduct fetal non-stress test	X		
12. Conduct oxytocin challenge test	X		
13. Perform sterile speculum vaginal examinations	X		
14. Perform fern/nitrazine tests	X		
15. Interpret fern/nitrazine tests	X		
16. Apply knowledge of fetal positions/presentations	X		
17. Assess fetal position using Leopold's maneuver	X		
18. Apply knowledge of labor complications			
19. Assess uterine contractions by palpations	X		
20. Auscultate abdomen for fetal heart sounds using doppler	X		
21. Apply external monitoring devices for indirect fetal heart rate monitoring	X		

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
ANTEPARTUM (continued)			
22. Apply spiral electrodes for direct fetal heart monitoring	X		
23. Operate fetal monitors	X		
24. Monitor fetal heart rate/contractions using fetal monitors cardio-tocometry	X		
25. Interpret fetal heart rate/contractions using fetal monitors cardio-tocometry	X		
26. Initiate procedures in case of fetal heart rate abnormalities	X		
27. Insert uterine catheters			X
28. Assist provider with insertion of uterine catheters	X		
29. Assist provider with vaginal examinations	X		
30. Assess progress of labor (e.g., contractions/dilation)	X		
31. Assess dilation, effacement, and station	X		
32. Set up incubators/isolettes	X		
33. Set up transport incubators	X		
34. Assemble obstetrical linen packs	X		
35. Coach patients/partners during labor and delivery process	X		
36. Perform perineal preparation/hygiene	X		
37. Initiate induction procedures	X		
38. Monitor induction procedures	X		
39. Terminate induction procedures	X		
40. Initiate ritodrine procedures	X[1]		
41. Monitor ritodrine procedures	X[1]		
42. Terminate ritodrine p dures	X[1]		
43. Initiate magnesium sulfate procedures	X		

[1]Performed by less than 50% of the staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
ANTEPARTUM (continued)			
44. Monitor magnesium sulfate procedures	X		
45. Terminate magnesium sulfate procedures	X		
46. Assist provider with amniotomy	X		
47. Assist provider with dilatation and effacement assessment	X		
48. Initiate procedures for intrauterine infusion	X		
49. Monitor intrauterine infusion	X		
50. Terminate intrauterine infusion	X		
51. Prepare delivery areas	X		
52. Assist provider with external version	X		
INTRAPARTUM			
53. Perform emergency delivery	X		
54. Perform circulation nurse duties during caesarean delivery	X[1]		
55. Administer and monitor pitocin intravenous therapy postpartum	X		
56. Apply knowledge of reasons for and types of episiotomies	X		
57. Perform episiotomy			X
58. Perform bulb/mechanical suction on newborns	X		
59. Clamp/cut umbilical cord	X		
60. Draw umbilical cord blood	X		
61. Assist mother with expulsion of placenta/membranes	X		
62. Assess placenta/membranes/umbilical vessels	X		
63. Weigh placentas			X

[1]Performed by less than 50% of the staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
NEWBORN			
64. Take APGAR readings	X		
65. Interpret APGAR scores	X		
66. Administer oxygen to newborns	X		
67. Receive newborn following delivery	X		
68. Assess newborn for maturity	X		
69. Administer medication to eyes of newborns	X		
70. Administer Vitamin K to newborns	X		
71. Measure length/weight/head circumference of newborns	X		
72. Identify newborns (e.g., footprints/bracelets)	X		
73. Set up neonatal cardiac monitors	X		
74. Interpret neonatal cardiac monitor readings	X		
75. Instruct patients on infant care	X		
76. Provide umbilical cord care	X		
77. Apply elbow restraints to newborns	X		
78. Maintain body heat of newborns	X		
79. Collect heel blood samples	X		
80. Apply ultraviolet lamps	X		
81. Administer IV push drugs to neonates	X		
82. Take fetal scalp blood samples			X

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
POSTPARTUM			
83. Assess uterine size, position, and consistency in the post-partum period	X		
84. Assess lochia	X		
85. Perform postpartum uterine massage	X		
86. Assess breasts in preparation for breast-feeding	X		
87. Teach breast-feeding to patient	X		
88. Provide intervention for difficulties in breast-feeding	X		
89. Assist patient with pericare	X		
90. Provide postpartum heat-lamp treatment	X		
FAMILY SUPPORT ACTIVITIES			
91. Organize pre-natal classes	X		
92. Conduct pre-natal classes	X[1]		
93. Notify authorities of births	X		
94. Teach family planning	X[1]		
95. Teach child development	X[1]		
96. Report possible abuse/harassment/neglect cases	X		
97. Refer victims of abuse/harassment/neglect cases	X		
98. Assess family support networks	X		
99. Provide parents with psychological support and community resources after fetal or neonatal death	X		

[1]Performed by less than 50% of the staff nurses

C - II. ADDITIONAL TRAINING FOR OBSTETRICS/NEWBORN

(Recommendations from survey participants)

ANTEPARTUM

-Fetal growth and development*
-Intrapartum fetal surveillance*
-Coronetric fetal monitoring*
-Childbirth coaching*
-OB cardiac arrest procedures
-Basic cardiac monitoring techniques
-Complicated and routine obstetrics
-Premature labor
-Amnionitis
-Pre-eclampsia
-Certification in sterile speculum exams*
-Certification to push IV and specialized drugs
-Basics of ultrasonography for purposes of biophysical profile determination

NEWBORN

-Neonatal assessment
-Breast-feeding*
-Neonatal Advanced Life Support (NALS)*
-Infant stabilization and transport

POSTPARTUM

-Postpartum care of caesarean section patients
-Teaching moms about how to care for themselves in the postpartum period:

  -Wound/episiotomy care
  -Nutrition
  -Signs of complications
  -Activity
  -Kegal exercises
  -Emotional support
  -Family planning*

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* Included in survey

C - III. Quoted Comments: Additional Training Needed - Obstetrics/Newborn

FAMILY PRACTICE HOSPITAL	
Director of Nursing Service	OB is practiced as a separate specialty in all our facilities. Given the OB knowledge explosion and medico-legal environment, I believe it's time we establish a 2-3 week formal training course leading to a subspecialty code K and require it at time of assignment.
Division Officer	Would like to see an obstetrics training program for OB nurses similar to OR nurse program - this is a specialty area that needs to be recognized, standardized, and supported in the Navy Nurse Corps.
Division Officer	Some items are no longer practiced in OB/Newborn. When residency programs exist in OB - the RNs are very limited in opportunity to practice OB/nursing skills and if it is their only experience - they are not capable of functioning as an OB nurse at another facility without significant additional training.
Obstetric/ Gynecology Surgeon	Areas most critical - evaluation of actual L&D with competency in monitor evaluating and documentation - clinic exams critical in some hospital settings - never required in others.
Obstetric/ Gynecology Surgeon	All L&D nurses should be NAACOG certified. NAACOG certified nurses should work L&D and should only be transferred off of L&D if they request. L&D should be treated as a critical care area. The most senior nurse corps officer is a LT with less than 2 years of L&D experience. This is dangerous. Inadequate and inexperienced staffing and poor attitude by NC leadership are contributing significantly to exodus of OB/GYN physicians from the Navy. Civilian RNs working L&D are, overall, better trained and more experienced than Navy nurses.
Obstetric/ Gynecology Surgeon	Nurse Corps officers in our facility should be sent to fetal monitoring classes outside of this facility.
Obstetric/ Gynecology Surgeon	The Navy needs a core curriculum for OB nurses. Nurses at this command need classes on postpartum, hemorrhage, etc.

FAMILY PRACTICE HOSPITAL (continued)	
Staff Nurse	In the area of obstetrics, cross-training to all areas of nursery, L&D and postpartum seems essential. Community involvement and willingness to teach/screen would also be desirable.
Staff Nurse	We have a level II NBN. Need more NALS courses offered, so all nurses are NALS prepared. As only one nurse is scheduled on nights, I would like more TAD's for conferences, etc., for fetal monitoring.
98 PLUS BED-SIZE HOSPITAL	
Director of Nursing Service	Anyone going overseas should have at least 3 months in OB/Newborn.
Nurse Midwife	I feel very strongly that Obstetrical/Newborn nurses need formal training prior to working in these areas followed by a preceptorship with an experienced nurse. I worked L&D overseas and was one of only two Navy nurses that had prior L&D experience. The other nurses had varied backgrounds, but were expected to "know" L&D after a 4 week orientation. Courses such as the Perinatal course offered by Naval Hospital, San Diego are a good start - although it is only a week long. I would like to see at least 3 weeks, to include antepartum, intrapartum, postpartum, and fetal monitoring.
Nurse Midwife	The best idea is some sort of extensive program of 14-20 weeks in duration where Nurse Corps officers can be taught the art and science of Obstetrics - dedicated nurses teaching their profession to other nurses. Teach - set up a program, demystify and inspire. When people have knowledge, they are no longer frightened and they can take action.

98 PLUS BED-SIZE HOSPITAL (continued)	
Department Head (OCONUS)	Task # 68 [*Conduct fetal non-stress test*]: I would have answered this question differently for the L&D unit and ante/postpartum wards. 9 for L&D and 4 for ante/postpartum. In the past, all NSTs were done on L&D. We are currently in the process of educating staff on ante/postpartum re: NST. All but one provider had previous experience with NST. Task # 111 [*Perform circulation nurse duties during caesarean delivery]*: the L&D nurses currently do not perform the duties of the circulating nurse during caesarean deliveries. However, we are in the process of training and educating the staff to do this providing the sections done in the OR are on the [Labor] deck when staffing permits.
Department Head (OCONUS)	NICU training for NICU nurses does include airevacs. Some of our patients come from other areas in Pacific, i.e., 3 airevacs do pick up premature infants.
Division Officer (OCONUS)	Nurses who desire, or may be assigned to, the OB/Nursery area when going to an overseas billet should receive at least 1-2 months each, training in a facility that has a significant population of high risk OB and Nursery (at least Level II).
Obstetric/ Gynecology Surgeon (OCONUS)	Nurses on the OB ward should be crossed trained with L&D and have a full understanding of the needs of antepartum, not just postpartum patients. Classes have been given here for FHR monitoring, PML, etc., which is a start in the right direction, but it would be helpful to receive trained nurses; not always lose the nurses once they've been trained and finally know the working of the ward.
Obstetric/ Gynecology Surgeon (OCONUS)	Nurses are sent to L&D with no experience in fetal/maternal monitoring. This is dangerous and totally irresponsible. Nursing Services should ensure that a nurse assigned to L&D either has recent experience and is trained in fetal monitoring or should be sent to a major teaching center for at least 6 weeks prior to being assigned to L&D. All nurses assigned to L&D should be required to pass a fetal monitoring course.
Obstetric/ Gynecology Surgeon (OCONUS)	New nurses would benefit from training in childbirth coaching, breast-feeding, postpartum care, and family planning.

98 PLUS BED-SIZE HOSPITAL (continued)	
Obstetric/ Gynecology Surgeon (OCONUS)	Although there are a few nurses with adequate previous experience or an exceptional aptitude to learn - the overall OB/GYN nursing skill and competence is abysmal. The two biggest reasons are DNS directives to assign highly-qualified OB nurses to other areas of the hospital despite (or because of) physician requests to have them assigned L&D, and Nursing Services resistance to TAD inexperienced nurses to large OB hospital wards for experience prior to beginning work (recommended time, at least 6 weeks). Overall, the civilian nurses show more/better aptitudes, experience, and attitude. The Navy nurses are more interested in sucking up to the nurse "high command" and moving off the wards than they are in "doing their job."
Obstetric/ Gynecology Surgeon (OCONUS)	At this institution, the L&D nurses are well versed in antepartum and intrapartum care. The OB ward, however, has had difficulties with nursing care of antepartum patients due to lack of knowledge of the "disease" processes, i.e., PM, IUGR, etc., and ambivalence towards learning these things.
Obstetric/ Gynecology Surgeon	OB/GYN is a highly specialized discipline. Nurses working in the L&D area need extensive training. Orientation programs should be sufficiently long enough to provide thorough working knowledge of the field. Preceptors should be assigned to new employees. Fortunately, our command has about 70% civilian nurses, all with L&D experience, which makes our job more efficient and less stressful.
Obstetric/ Gynecology Surgeon	L&D nurses must be formerly trained and certified in this area if consistency of quality of care is the goal. This is a high risk area, medical-legally, so actual training or experience is very essential. NC traditionally have limited experience on L&D and no continuing medical education in this area because they're supposed to be "jack-of-all-trades." Specialty areas - ER, ICU, L&D, Newborn Nursery - have gotten too technological and too advanced for most general nurses and they can't feel comfortable when thrown into these areas. L&D NURSES MUST BE A SPECIALTY AREA!!!

98 PLUS BED-SIZE HOSPITAL (continued)	
Staff Nurse (OCONUS)	All nurses coming from CONUS to an overseas command should have an orientation to L&D, postpartum and nursery before arrival. Allow more nurses who already possess clinic knowledge in obstetrics, newborn nursery to come overseas.
Staff Nurse (OCONUS)	I think it would be helpful for both the nurse corps officer and the new command to which assigned to have him/her obtain hands-on L&D experience in a facility where many deliveries are performed. I have recently been transferred to an overseas hospital where delivery rate is low < 50 per month. Without my previous OB experience as a staff nurse on a busy OB deck in a teaching hospital, I would be very apprehensive about being assigned to an OB floor. The orientation program is adequate, but in no way prepares an untrained/inexperienced L&D nurse for the independent decision-making responsibility required in a small facility. In a large facility there are usually ample personnel to act as resources, but in a small facility you will be lucky if the other 1-2 nurses on the shift with you have had extensive experience in OB. Typically, a nurse pursuing overseas orders will spend 2 weeks on an active labor deck before being PCS to a new command. This is not enough time to feel comfortable with normal L&D procedures. Four weeks may be a more realistic period of time to devote to training.
Staff Nurse (OCONUS)	PALS, ACLS, neonatal intensive care classes to update clinical skills, neonatal transport classes.
Staff Nurse	Specific courses that deal with the normal physiology of the pregnant woman and neonate courses specific to complicated obstetrics and neonatal.
Staff Nurse	Certification training in sterile speculum exams. Basics of ultrasonography for purposes of biophysical profile determination.

98 PLUS BED-SIZE HOSPITAL (continued)	
Staff Nurse	Courses and/or training seminars or sessions would better benefit the nurse corps officer in specialty areas. The only OB/GYN that I had as background was in college. Most of my experience has been OJT. Hands-on experience is good, but I know I could have benefitted from some OB training. I have had the opportunity to cross-train to labor delivery and that offered me an insight into obstetrics. A specialty area is just that, and you should be specially prepared before you are entered into it. The ramifications in obstetrics are heightened when you look at the fact that you are dealing with multiple life and factors affect.
50-98 BED-SIZE HOSPITAL	
Division Officer	As in CCU or ICU, the L&D area needs special training of about two weeks classroom and a three-month probation time. Most of the nurses in this field teach/train themselves or pay for their own education.
Staff Nurse (OCONUS)	All nurses being assigned overseas should be given a minimum of 2 months of intense maternal/newborn training. This is a very utilized area overseas and with the low number of births per month, usually 20-25. The availability to expose new orientees to enough experience with L&D is minimal.
Staff Nurse	Some areas left blank were done so because they are not performed at this facility: ritodrine infusion, intrauterine infusion.
Staff Nurse	In a facility this size, nurses need to have at least 3 weeks at a bigger facility that has more deliveries so they get the volume and get to see the unusual. Sometimes you have to learn by doing and getting to be able to do it will take constant repetition. At this time we have a nurse new to L&D, part of OB, and she has only seen/participated in 5 deliveries since September; she will be off orientation in a couple of weeks.

50-98 BED-SIZE HOSPITAL (continued)	
Staff Nurse	Breast-feeding being offered parents which frustrates and upsets new parents. All nurses need to be given literature on orientation indicating correct advice so that all nurses give same advice...or all nurses need to be given TAD to breast-feeding seminars. All nurses should be instructed in basic ultrasound and probably AFI. Nurses should be sent TAD at least once every 3 years for update, review of perinatal nursing - nursing standards are expanding and changing! Many nurses, in my observation, are performing in the "dark ages", are resistant to change, and reluctant to assume more responsibility. EXPAND.
BELOW 50 BED-SIZE HOSPITAL	
Director of Nursing Service	Obstetrics: Military nurses here work only in Postpartum and Newborn Nursery; therefore, L&D skills are low, but a nurse in L&D would need those skills at "hands-on" level.
Assistant Director of Nursing Service	If training **was available** we are unable to support it due to staffing shortfalls. Plus, most of our TAD money goes to bring TAD nurses here to fill *empty billets. (Major Teaching Facility)* keeps cancelling critical training evolutions like fetal monitoring, which we can not afford to seek as civilian programs. We get little support from anyone. Isolated duty stations, like [this command] should have more education and training support NOT less. Due to the staffing shortfalls, we get essentially no training money. Critical courses needed on a recurring basis: neonatal assessment, skills/pediatrics, fetal monitoring (basic and advanced), and basic cardiac monitoring techniques.
Assistant Director of Nursing Service (OCONUS)	All staff nurses should have some training in L&D. It takes 6 months to completely train an L&D nurse from ground zero.

BELOW 50 BED-SIZE HOSPITAL (continued)	
Nurse Midwife (OCONUS)	HSETC should offer a formal perinatal nursing education course (similar to the OR nurse course). The course should be offered multiple times a year. New nurses in the perinatal field (or scheduled to go to small hospitals where they are likely to work in perinatal areas) should attend the course. The course should be both didactic and hands-on and offered at facilities with a large volume of deliveries. Course should be run by experienced RNs and a physician as an adjunct advisor.
Division Officer (OCONUS)	All L&D nurses should be required to become certified in Neonatal Resuscitation near the beginning of their time on L&D. A short, formal school for L&D nurses would be nice (like the one for OR nurses). It is very frustrating when at large teaching hospitals, L&D nurses are not allowed to practice the skills they have learned at smaller hospitals.
Obstetric/ Gynecology Surgeon	Specific training on complicated and routine obstetrics; intrapartum fetal surveillance (e.g., FHM [fetal heart monitoring], etc.). Be at least 0-3 before being assigned to a small naval hospital.
Obstetric/ Gynecology Surgeon	This is not the place to train people. Even though OB is the biggest share of patient care, the nurses will never, for example, do enough vaginal exams to be accurate and thus, a small hospital such as this one is not the place to train. Besides, running a very busy OB/GYN practice for one person, I do not have time to train nurses OJT (although, I'm currently doing a lot of this). It should be mandatory that RNs spend 3-6 months on a busy OB ward before transfer overseas where they certainly will be needed and asked to do obstetrics - a specialty that is very specialized and where things can go wrong very fast.

BELOW 50 BED-SIZE HOSPITAL (continued)	
Obstetric/ Gynecology Surgeon	Most nurses in the Navy I have worked with during the past 6 years have "learned on the job" in OB/GYN areas. The most experienced and accomplished nurses almost always were civilian contract nurses. Military nurses are at a disadvantage because of the "required" rotations they undergo. You cannot be a "jack-of-all-trades" when it comes to CCU, ICU, NICU, L&D, etc., and I feel it takes over a year to be really familiar with any of these critical care areas.
Staff Nurse (OCONUS)	We need (1) coronetric fetal monitoring classes (FORMAL); (2) TAD for nurses with no obstetric/newborn background to a facility that treats greater numbers and higher risks; and (3) major commands in CONUS should prepare a nurse billeted for OCONUS with at least 6 months obstetrical/newborn experience.
Staff Nurse (OCONUS)	Most training is informal OJT given by providers. Providers are great for allowing nurses more hands-on experience as needed - however, very little training is offered by command (or TAD for training). NC would benefit from intensive hands-on courses at major facility for high risk patients. Courses on fetal growth & development.
Staff Nurse (OCONUS)	1. NALS instruction - we are working on getting everyone certified. 2. Infant stabilization and transport CONUS. 3. Level II and level III newborn care in case we are not able to transport an infant who would normally be in a level III nursery.
Staff Nurse (OCONUS)	I strongly feel that nurses need additional training in specialty areas such as the three described in this survey. Being assigned to a small hospital means having to utilize what knowledge base you have on a particular specialty area. For example, I had absolutely no training, formal or informal, in OB/newborn. What I have learned so far has been all hands-on experience. I strongly encourage the senior management to allow their staff members to obtain the necessary training needed when coming to a very small command.

BELOW 50 BED-SIZE HOSPITAL (continued)	
Staff Nurse (OCONUS)	I have no L&D/OB training. All experience is from OJT training since arriving here. Would be nice to either send experienced RN's (OB/L&D) here or send nurses to a 4 week training session at a larger duty station prior to arriving here.
Staff Nurse	Optimal initiate 2-4 weeks schools for OB/GYN. Also attend at least OB/GYN school before allowed at overseas hospital.
Staff Nurse	More TAD assignment to fetal monitoring courses. High risk OB courses are needed to better enable us to give quality care.
Staff Nurse	4-6 weeks minimum training in L&D for nurses without significant prior experience in this area, or in need of a refresher course.
LOCATION MISSING	
Nurse Midwife	NALS, fetal monitoring classes, ACLS, OB and Nursery staff.

Appendix D: Results of Psychiatry Task Analysis and Additional Training Comments

I. Psychiatry Task Inventory - Recommended training levels were established using the Decision Tree in Figure 1, page 22.

II. Additional Training for Psychiatry - These were obtained from write-in comments from survey participants.

III. Quoted Comments: Additional Training Needed - Psychiatry: Listing of comments, sorted by facility size and job title.

D - I. PSYCHIATRY TASK INVENTORY

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
SAFETY			
1. Inspect patient belongings for contraband	X		
2. Confiscate and secure contraband and potentially hazardous items	X		
3. Account for location/whereabouts of patient	X		
4. Encourage/reinforce patient's independence and participation in self-care in accordance with provider's orders	X		
5. Observe for and report self-injurious behavior or verbalizations	X		
6. Recognize and report signs of patient's suicidal tendencies	X		
7. Recognize and report signs of patient's homicidal tendencies	X		
8. Observe for and report behavior/gestures indicative of escape or elopement	X		
9. Observe for and report behavior/gestures indicative of concealment	X		
10. Recognize and report situations requiring immediate response	X		
11. Recognize need for/recommend ward search and seizure	X		
12. Participate in special ward search and report findings	X[1]		
13. Recognize need for/recommend restriction of visitors	X		
14. Recognize/report need for additional support prior to intervention with patient	X		
15. Recognize/report need for emergency equipment and medication based on patient's actions	X		
16. Recognize/report need to intervene with/restrain patient	X		
17. Recognize need for and initiate/assist in precautionary measures	X		
18. Recognize need for separation or isolation of patient	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
SAFETY (continued)			
19. Recognize need for/participate in show of force	X		
20. Assist in nursing measures to control agitated patient (e.g., disarm, stop fight, arm hold)	X		
21. Counsel patient utilizing therapeutic intervention criteria (i.e., sequence method of restraint)	X		
22. Assist in administration of medication to control/sedate disruptive patient (i.e., chemical restraint)	X		
23. Assist in application of restraints to physically control combative patient (e.g., soft restraints, straps/belts)	X		
24. Monitor and provide care for patient in restraints (e.g., range of joint motion exercises, circulation checks)	X		
25. Monitor and provide care for patient on precaution/restriction (e.g., prisoner-at-large)	X		
PATIENT ORIENTATION			
26. Explain/clarify reason(s) for admission in accordance with provider's orders	X		
27. Orient patient to Milieu therapy	X		
28. Discuss limitations and potential problems on leave/liberty	X		
PATIENT ASSESSMENT			
29. Receive/admit psychiatric patient	X		
30. Conduct basic psychiatric admission interview (i.e, history, complaint, mental status, initial attitude/motivation, physical characteristics)	X		
31. Administer the Minnesota Multiphasic Personality Inventory (MMPI)	X[1]		
32. Observe overall behavior patterns/changes	X		
33. Observe/report effect of visitors on patient's behavior	X		
34. Monitor patient authorized use of potentially dangerous drugs	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

PATIENT ASSESSMENT (continued)	RECOMMENDED TRAINING LEVELS: Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
35. Monitor therapeutic environment/activities in accordance with local policy (e.g., privileges/status system)	X		
36. Observe/monitor patient in work therapy assignments	X[1]		
37. Gather feedback and maintain documentation on patient's communication and socialization	X		
38. Observe for and report patient's primary mode of communication (e.g., verbal/nonverbal method)	X		
39. Observe for and report patient's level of communication (e.g., approach, amount, depth)	X		
40. Listen to and report content of patient's verbal communication (i.e., patient's words/subjective symptoms)	X		
41. Administer psychological tests/questionnaires in accordance with local policy	X[1]		
42. Score tests/questionnaires in accordance with local policy			X
43. Report/maintain documentation on patient screening	X[1]		
44. Observe for and report patient's eating pattern (e.g., maintain meal chart)	X		
45. Observe for and report patient's sleeping (e.g., maintain sleep chart)	X		
46. Observe for and report manifestations of substance abuse	X		
47. Observe for and report outward signs of patient's general emotional condition/mood (i.e., affect, voice quality)	X		
48. Observe for and report factors that may influence patient psychological state	X		
49. Observe and report defense mechanisms used by patient	X		
50. Observe for and report patient's body movements/positioning/muscle tone	X		
51. Observe for and report patient's level of anxiety	X		
52. Recognize and report effect of patient on staff/others (i.e., manipulation, seclusive, intrusive, seductive attempt)	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
PATIENT ASSESSMENT (continued)			
53. Observe for and report patient's response to protective interventions/precautionary measures	X		
54. Observe/monitor patient in recreational and social activities	X		
55. Ascertain and report patient's response to discharge and after care (i.e., follow-up support)	X[1]		
56. Monitor patient requiring supervision	X		
57. Monitor patient authorized use of phone in accordance with local policy	X		
58. Recognize and report behavior indicative of impaired perception (e.g., hallucinations, delusions, illusions)	X		
59. Assist with screening of ambulatory care psychiatric patient in accordance with local policy	X[1]		
60. Recognize and report evidence of complicated bereavement (e.g., prolonged grief, extensive loss)	X		
61. Provide basic interventions for patient experiencing complicated bereavement	X		
62. Recognize and report behavior indicative of acute/delayed stress caused by combat or disasters (i.e., post traumatic stress, delayed)	X[1]		
63. Assist/conduct group/individual crisis intervention in non-ward environment (e.g., ship, line command, Marine Corps)	X[1]		
PLANNING			
64. Participate in family advocacy programs	X[1]		
65. Formulate multi-disciplinary treatment plan	X		
66. Modify multi-disciplinary treatment plan	X		
67. Participate in multi-disciplinary treatment team conference	X[1]		
68. Assist in planning for patient's discharge/follow- up care (e.g., objectives/occupation/Navy environment)	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
MEDICATION ADMINISTRATION			
69. Observe for and report patient's response to effect of psychotropic medication (i.e., adverse/beneficial)	X		
70. Clarify administration of prescribed medication for patient on leave/liberty	X		
71. Administer psychotropic medication in accordance with local policy	X		
72. Recognize and report patient's need for medication (e.g., medication ordered, prn)	X		
73. Observe for and report overall effects of medications on patient's behavior	X		
74. Recognize and report signs/symptoms of extrapyramidal reaction	X		
75. Recognize and report signs/symptoms of toxicity	X		
76. Administer emergency care for severe drug reaction	X		
THERAPY			
77. Assist with electroconvulsive therapy in accordance with local policy			X
78. Position and restrain/secure patient for medical procedures (e.g., including catatonic,motorically retarded patient)	X[1]		
79. Provide supportive/interactive relationship with patients in accordance with provider's orders and local policy	X		
80. Utilize appropriate experiences and unscheduled activities to encourage interaction and communication	X		
81. Recognize need/make recommendation for patient's consultation with support personnel	X		
82. Assist in routine assessments of psychiatric patient (i.e., daily observation, impressions of relationships, status)	X		
83. Prepare isolation room for patient (i.e., quiet room)	X		
84. Assist in admission and management of special psychiatric patient (e.g., medevac, acutely psychotic/combative)	X		

[1]Performed by less than 50% of staff nurses

Familiarization: Information which includes basic facts, components, capabilities, etc.

Hands-On/Thorough Knowledge: Training which includes actual or simulated hands-on practice, or in-depth knowledge requiring judgment or application of theory.

	RECOMMENDED TRAINING LEVELS		
	Not Recommended for Training	Recommended Training at the Familiarization Level	Recommended Training at the Hands-On/ Thorough Knowledge Level
THERAPY (continued)			
85. Ensure patient has been restrained/secured for evacuation/transport in accordance with provider's orders	X		
86. Engage in appropriate recreational therapy with patient	X		
87. Participate in occupational therapy/work along with patient	X[1]		
88. Observe/participate in group therapy sessions and report patient's behavior	X[1]		
89. Participate in feedback sessions (e.g., post group/post community)	X[1]		
90. Monitor and provide care for patient with seizures/convulsions	X		
91. Monitor and provide care for patient in isolation	X		
92. Assist in providing supportive, protective measures for patient experiencing acute/delayed stress	X		
TEAM BUILDING/MAINTENANCE			
93. Conduct suicide prevention/stress management/TEAM (Treat Everyone As Me) training and other community outreach programs	X[1]		
94. Maintain psychiatric quality assurance standards	X		

[1]Performed by less than 50% of staff nurses

D - II. ADDITIONAL TRAINING FOR PSYCHIATRY

(Recommendations from survey participants)

SAFETY

-Crisis intervention - emotional and violent
-Maintaining a safe milieu for both patients and staff
-Suicide prevention*
-Suicide assessment*

PATIENT ASSESSMENT

-Interview techniques

MEDICATION ADMINISTRATION

-Psychotropic medications*
-Psychopharmacology

THERAPY

-Group facilitation/supervision
-Group therapy*
-Psychotherapy
-Psychiatric theories of psychosis and personality disorders

TEAM BUILDING AND MAINTENANCE

-Administer/participate in unit continuing education
-Legal issues
-Managing psychiatric patients on medical-surgical ward
-Quality assurance*
-Unique discipline of military psychiatry

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* Included in survey

D - III. Quoted Comments: Additional Training - Psychiatry

FAMILY PRACTICE HOSPITALS	
Director of Nursing Service	Psychiatric units are also only at tertiary care centers. Nurses who work there definitely need formal training.
Division Officer	Needs to be education-oriented vice training. Needs to deal with human behavior and pathology.
Division Officer	Inexperienced generalist is expected to work unsupervised and be in charge on the off hour (3-11, 11-7) shifts. I am not negative toward the system or the Navy. I have a long respect for the Navy going all the way back to my grandfather. I just took this opportunity to make some comments that I hope might help make the Navy NC a little better off. I would like to see the Navy have a psychiatry training course for nurses like the Army does.
Staff Nurse	My experience in the past three years in the Navy is that compared with the civilian sector the Navy has done a poor job recruiting nurses with special interest in or training in psychiatry. Most nurses have little psychiatric nursing experience and often have little interest in the field. They are ordered to psychiatry and when they gain experience, they rotate to another area. Greater emphasis on continuing education is needed in this area and experience people (civilian if necessary) need to remain as experience teachers in the department as other (active duty) rotate away.
Staff Nurse	We could use all the training we could get! At present it is nil. I would like some training in psychiatric nursing especially since I'm supposed to be a psychiatric nurse. Also, at this command, it is virtually impossible to go to inservice for further training. The reason is always "staffing won't permit it." My education has virtually ceased here.

98 PLUS BED-SIZE HOSPITAL	
Director of Nursing Service	Staff nurses assigned to Psychiatry should go through a one month inpatient training program at Bethesda, Portsmouth or San Diego. 2-week alcohol health-care providing course would help also. Crisis intervention, legal issues, quality assurance, suicide prevention, and assessment.
Assistant Director of Nursing Service	Psychiatry. . . where individuals need some expertise. Within the NC, we tend to lack the numbers needed. . . . .
Division Officer	Psychiatric nursing is a specialty that needs to be recognized. It requires a minimum of 6 weeks of education as the OR nurses do. In fact, within the specialty it takes an RN 3 months to feel confident and 6 months to **be** confident. The specialty requires an in-depth knowledge of self to be therapeutic with patients.
Staff Nurse (OCONUS)	1. Managing psychiatric patients on a medical-surgical ward. 2. Psychotherapy. 3. Crisis intervention - emotional & violent. 4. Psycho pharmacology.
50-98 BED-SIZE HOSPITAL	
Director of Nursing Service	Psychiatry needs emphasis - unable to do other than OJT.
Divsion Officer	Suggest assignment with masters-prepared Psychiatric Clinical Nurse Specialist as a prerequisite for independent duty/division officer billets. Advantages: Application of theory to clinical practice, clinical competence, extensive group therapy experience as a co-facilitator, working knowledge of transference/countertransference issues in patient and staff communities, and awareness of neuro-psychiatric technician training and experience.
Psychiatrist	Upon talking to other nurses, psychiatric nurses expressed interest in group therapy, interview techniques, psychotropic medication, and update in psychiatric treatment.

50-98 BED-SIZE HOSPITAL (continued)	
Psychiatrist	The training of nurses in the psychiatric field is a must. Hands-on and didactic knowledge is very important. I must say the longer they are exposed in seeing psychiatric patients, chances are we are getting a professional and well-experienced staff. I must say 6-12 months stay in psychiatric ward is a must. With this experience they can be assigned anywhere.
Psychiatrist	Recommend that Navy nurses be required to participate in training in civilian and community programs prior to assignment on a Navy psychiatric unit.
Staff Nurse	I would like to see a three week course offered four times a year (two on each coast) put on by a psychiatric training hospital. The first two weeks would be strictly didatic governing the following areas: - maintaining a safe milieu for both the patients and staff - suicidality - psychodysmic theories of psychosis and personality disorders - psychopharmocology - introduction to both group and individual psychotherapy - the unique discipline of military psychology The last week would be spent on military psychiatric work putting into practice the first two weeks.
BELOW 50 BED-SIZE HOSPTIAL	
Director of Nursing Service (OCONUS)	What makes sense at my hospital is the assignment of at least 2 psychiatric nurses, not just one as it happens from time to time. If provided, nurses could further each other's interest, knowledge, and training while seeking additional instruction from formal courses. They should arrive at their assignment with an agenda to be agreed upon by the senior nursing and the senior psychiatric staff so that a more coordinated treatment program can be implemented.

BELOW 50 BED-SIZE HOSPTIAL (continued)	
Assistant Director of Nursing (OCONUS)	All staff nurses should have some training in L&D and in psychiatry. Nurses are responsible for psychiatric patients for many hours of the day, without a psychiatrist onboard.
Department Head (OCONUS)	All NC staff needs to be trained in basic psychiatric nursing when they are detailed to OCONUS hospitals with no psychiatric in-patient units or psychiatric nursing billet.
Staff Nurse	Need extensive psychiatric training as we stabilize (treatment) and medevac out as soon as possible. Always crisis management is a non-safe (no dedicated safe room) environment. Need to deal with need to separate psychiatric patients from their "home environment" in order to get treatment. Must deal with power of attorney and other tasks needed to prepare them to leave the area. And this in addition to caring for patients of other services (some times in the same room due to space constraints) creates problems.
LOCATION MISSING	
Psychiatrist	Psychiatry Nursing course and training.
Job Title Missing	Group Facilitation/Supervision, Psychiatry.

Appendix E: Listing of Other Quoted Comments

Orthopedics

FAMILY PRACTICE HOSPITAL	
Department Head	Is the Nurse Corps once again attempting to distance itself from basic nursing functions? This survey seems designed to identify educational/training necessary to create nurse practitioners. Certainly some of the survey tasks should be performed competently by ward nurses, others by OR nurses, others by nurses assigned to orthopedic clinics. I would much rather see nurses do a better job with basic nursing functions like dressing changes, prevention of pressure sores, etc., than for them to be knowledgeable about halo application or the physiology of osteoporosis.
Orthopedic Surgeon	A much more appropriate survey and area to consider is the need for special training in orthopedic Operating Room Nursing. Rarely is the nurse assigned to the orthopedics OR familiar with the equipment and supplies needed or available for orthopedics operations. As soon as a nurse develops a working knowledge of the gear used and operations performed, they are transferred (within the OR department or PCS). A similar situation exists regarding corpsmen scrub technicians, often significantly slowing cases - a serious problem rarely found in civilian facilities, as nurses and technicians are allowed to specialize in orthopedic cases.
Orthopedic Surgeon	Some [tasks] could apply to corpsmen rather than nurses, but nurses need to know how to show corpsmen.
Orthopedic Surgeon	Navy nurses are undermanned. We cannot staff wards and same day surgery, let alone specialty clinics and wards. Rotation policy, utilization of only Jr. RNs in clinical care prevents true expertise in any given clinical area.
Orthopedic Surgeon	Corpsmen have performed the functions intimated in this survey and done well. I have no objections to nurse supervision of the corpsmen. Also, they should help in some of the administrative functions of the department.
Orthopedic Surgeon	Almost all tasks are performed by corpsmen, not nurses, who are relegated to administration rather than patient care. This survey is inane.

FAMILY PRACTICE HOSPITAL (continued)	
Orthopedic Surgeon	Navy nursing: Doing the proper paperwork. My experience here and in Saudi is that the corpsmen do much of the work. I think Navy nurses vs civilian nurses do too little. They seem not to be interested in hands-on patient care, but rather on managing and advancing careers. It is ridiculous that there is so much jumping around. It seems as soon as someone is trained in orthopedics and becomes familiar with equipment (and there is a lot to know) they are shuffled. OR nurses are intimidated by orthopedics and need to be trained for orthopedics and kept in orthopedics - just like the MDs and HMs.
Orthopedic Surgeon	What are the goals of the survey? Are we trying to improve orthopedic knowledge for the ward nurse or is this to make nurse practitioners? How can the Navy afford nurse practitioners when there aren't enough nurses to care for the patients on the ward? Let's improve basic concepts of nursing the orthopedic patient before we specialize a group of nurses who want to be orthopedic surgeons. Let's have priorities!
Orthopedic Surgeon	Many functions of "orthopedic nurse" are provided by orthopedic technicians at this facility. The demands and expertise varies for nurses in ER, OR, and on the wards. We have no generic "orthopedic nurse" because nurses in these 3 areas assist with care of orthopedic patients. Due to the shortage of corpsmen, nurses also provide unskilled "hotel" type labor: "empty bed pans, serve meals, etc." Most training of nurses is OJT at this command.
Orthopedic Surgeon	Some areas where nurses are below average are areas that they do not commonly see in this institution but should be familiar with anyway.
Staff Nurse	Our orthopedic patients go to a general surgery floor. Orthopedics is not considered to be a specialty area. Other than ward orientation and occasional inservices on the subjects, we do not receive any formal training in the area of orthopedics. However, I think that it is a good idea and hopefully, as a result of this survey, we will have more training in this area.
Job Title Missing	Our orthopedic patients are cared for on a general surgical/surgical specialties ward. The nurses assigned to this ward are expected to care for a wide variety of patients. Orthopedics comprises only approximately 1/4 of the patients on the ward at any given time.

98 PLUS BED-SIZE HOSPITAL	
Orthopedic Surgeon (OCONUS)	Fewer nurses with clipboards and more direct patient care. Less delegation of tasks to corpsmen. OJT in orthopedic clinic paperwork. Train nurses to understand orthopedics, including clinic, OR, and ward experience. Train/educate them about myriad reams of paperwork in each environment and how they are related.
Orthopedic Surgeon	The majority of tasks entered on survey are not done by nurses - instead, by corpsmen. They delegate nearly all tasks to corpsmen anyway. The best military orthopedic nurse is one who can schedule patients, get all the paperwork together, check laboratories, make phone calls, and run interference - handle calls in an overburdened military environment where physicians have no ancillary support.
Orthopedic Surgeon	I would welcome Nurse Corps participation in orthopedics, but it seems to me nurses are almost as scarce as orthopedic surgeons.
Orthopedic Surgeon (OCONUS)	I have never had a nurse assist me in clinic or in application of traction or casts. Only orthopedic technicians have been available for assistance in such procedures. As nurses are supposedly in charge of these corpsmen, it would be nice if they had more understanding of what the corpsmen do.
Orthopedic Surgeon	This survey is difficult to answer as written for several reasons, and consequently, the answers may be misleading. Many of the tasks in the survey are not performed by nurses at my facility, but rather corpsmen or physical therapists. The nurses therefore do not have the opportunity to demonstrate any proficiency in these areas and have no opportunity to maintain any skill they might have. In general, I doubt most of the nurses know how to do some of these tasks at all. Additionally, there are a great many questions regarding procedures, such as traction, which are so rarely used that the nurses again have no opportunity to demonstrate or maintain proficiency. In the OR, our nurses only circulate - corpsmen scrub, so nurses do not assist in procedures, apply dressing, etc. And on the ward, the nurses act mostly to supervise corpsmen - they have little hands-on work.
Orthopedic Surgeon	NC officers rely heavily on the orthopedic technicians to perform many of the tasks covered in the survey (at our hospital). Unfortunately, this has caused them to decrease their expected performance level on many standard nursing matters pertaining to adjusting orthopedic appliances, traction, dressing, etc.

98 PLUS BED-SIZE HOSPITAL (continued)	
Orthopedic Surgeon (OCONUS)	I have been very pleased with the orthopedic nursing care here at [98+ OCONUS]. Although there are many shortcomings here nursing is a pleasant exception to the rule.
Staff Nurse	At this facility, we see primarily general and orthopedic/surgical cases. The majority of the orthopedic cases are relatively simple arthroscope procedures requiring no special skills to care for. The majority of the nurses are ensigns with no prior orthopedic experience.
Staff Nurse	Inservice training was done almost daily, but not specifically on orthopedic matters. We focused on care of catheters, disease processes, aspects of patient care. Most nurse corps officers are anxious to move to any other department where training in a specialty is more intense. Unfortunately, orthopedic training is not offered on the ward - only in the clinic.
50-98 BED-SIZE HOSPITAL	
Division Officer (OCONUS)	As D.O. of same-day surgery, our need for detailed knowledge of orthopedics is not great, but even a basic understanding would be helpful. Unfortunately, our staffing is stretched and that impacts on our flexibility.
Orthopedic Surgeon (OCONUS)	In general, I feel that most nurses who work in the ED/ER do a fairly good job with orthopedic patients. Their knowledge of orthopedic injuries is poor except for very common things like ankle sprains, shoulder dislocations, and wrist fractures. Overall, though, ER nurses seem smarter, more interested than ward nurses. I find ward nurses to be practically inept with regard to N/V assessment and general care of orthopedic patients. They seem to rely on the therapists and MDs. I don't trust them to do an accurate N/V assessment, and I'm not sure about their skin care/pm care. The nursing staff seems to do very little except pass medications and order the corpsmen around. They have a lot of authority, rank, and responsibility over corpsmen, but I'm not sure they deserve it. They should be teaching the corpsmen rather than ordering them to do menial work. However, I don't think they have enough training or interest in orthopedic care.
Orthopedic Surgeon	I have left several items blank, not because nurses should not perform them, but because the nurses at our facility do not perform them. Our orthopedic nurses do not get sufficient training in orthopedics. This also was true at [Major Teaching Facility].

50-98 BED-SIZE HOSPITAL (continued)	
Job Title Missing	I am not currently working in a specialty area but am assigned to nursing education. Responses were based on current observations of practice and past assignment in ER and L&D. The knowledge and competencies of an orthopedic nurse in a small hospital with only minor orthopedic cases is lacking due to a large dependence upon the orthopedic technician. There is little need for the nurse to intervene in the technical aspect because the orthopedic technicians need to maintain their skills.
BELOW 50 BED-SIZE HOSPITAL	
Division Officer	Our facility does not utilize much of the equipment mentioned (i.e., halo or cervical traction, Zimmer frame, Circle-electric bed, Stryker, TENS). Therefore, these questions were rated below average. This reflects a lack of knowledge/familiarity, not poor performance.
Orthopedic Surgeon (OCONUS)	Little nursing assistance with orthopedic patient care. Nurses at this facility are much more concerned with paperwork and collateral duties than delivery of patient care. Some individuals that are self-motivated do not seem to receive **any** administrative support for further training in the area of patient care. Recognition and advancement seem to be based entirely on political deference and paperwork - not patient care. USN patient care seems to be entirely concerned with paperwork and CYA. There is little concern for actual outcomes as they relate to quality medical care.
Orthopedic Surgeon	Many of the items are performed by the orthopedic technicians and physical therapy technicians.
Orthopedic Surgeon (OCONUS)	Most tasks are not required or N/A [not applicable] at this USNH but performed by surgeon on duty.
Staff Nurse	Difficult to measure the nurses' knowledge of orthopedics from survey. The survey relied on task oriented procedures.
Staff Nurse	Since we are a very small hospital with no ICU, we do not do more than routine cases. Therefore, the need for additional training is not necessary here. Also the survey asked about what Navy nurses do (not to include the corpsman?). This may affect your results since the primary job of the Navy nurses is to teach the corpsmen. For example I never teach crutch walking since our corpsman can; therefore, I left that question blank.

LOCATION MISSING	
Orthopedic Surgeon	It seems ironic that the solution should be part of the problem; as a general commentary, nurses spend far too much time pushing paper and chasing corpsmen to be expected to be adroit at/with the plethora of orthopedic nursing demands. To add more "training time" which always transforms into "meeting time" is risking compounding the situation. Orthopedics is a hands-on specialty, a vital requisite interaction between provider and patient that requires certain skills. Skills that are acquired by doing, not by watching the video. For nurses interested, or by default, engaged in orthopedic care, they should be required to spend time in orthopedic cast room, clinic, and ORs - sort of the junior interns for two weeks, especially at a larger, voluminous hospital in orthopedics. Nurses not interested in orthopedics, except ER nurses, can watch the videos.

Obstetrics/Newborn

FAMILY PRACTICE	
Division Officer	The NC needs formal training courses in OB and Nursery that should be standardized throughout the system. Hands-on experience/training is only as good as the person who is teaching. Frequently your preceptor has only had 6 months experience and lacks the knowledge necessary to teach.
Division Officer	The area of OB/Newborn should be broken down. At my facility the area is 3 separate wards: L&D, Nursery, and Postpartum. We encourage cross-training, but many RNs can not work in the other areas due to lack of formal training. Therefore the survey was hard to complete.
Division Officer	Nurses are not utilized according to knowledge base. We have NAACOG certified nurses working on surgical units, supervising, etc. and a certified nurse midwife working as a staff nurse. Nurses are moved frequently, not allowing continuity. Corpsmen only allowed to stay 6 months on ward. OB/GYN needs to be considered a specialty area and thus allow staff to remain there the entire tour of duty.
Obstetric/ Gynecology Surgeon	The nurses in the Navy should be given more flexibility and more hands-on experience in the management of the patient. We have very competent nurses that are nullified by the system.
Obstetric/ Gynecology Surgeon	A few nurses are exceptional and motivated, but most are just doing their "9 to 5" and have no interest in real obstetrical nursing. 12-hour shifts would go a long way in improving nursing morale.
Obstetric/ Gynecology Surgeon	After nurses achieve competency as L&D nurses, they are transferred to other areas. OB should be a specialty like an ICU nurse. Prenatal care, L&D nurses **today** require much more training and responsibility than several years ago. Why not have a few well trained nurses vice giving a lot of nurses a little training.
Obstetric/ Gynecology Surgeon	This survey is an excellent idea, but I fear 15 years too late. I have served in all types of facilities and am impressed that nurses try very hard to meet needs, but resources of funding and command support, especially in small hospitals like [Less Than 50 Beds OCONUS], has been financially inadequate and subject to physician involvement, when MO's are already stretched to breaking point. OJT in small hospitals has always been dangerous.

FAMILY PRACTICE (continued)	
Obstetric/ Gynecology Surgeon	The single biggest factor in the retention of obstetricians as relates to nursing is the excessive turnover rate of nurses. Nurses come to L&D with no experience, receive OJT, and transfer after 12-18 months when they are finally trained. The second largest factor is lack of support from senior nurses and a commitment to practicing 1990s OB nursing with resultant high medical/legal exposure. The Navy refuses categorically to endorse the nursing standards contained in "Standards for Obstetric Gynecologic Services" and "Guidelines for Perinatal Care." The Navy's failure to support OB/GYN will result in a continued exodus.
98 PLUS BED-SIZE HOSPITAL	
Department Head	Nurses do a good job taking care of specialty patients, considering the amount of training they get. Many request and are granted TAD for training. There are no minimum requirements for psychiatry and orthopedics, as there is with OB.
Obstetric/ Gynecology Surgeon	Civilian nurses predominate in numbers and are supervisors in L&D and Newborn area. Postpartum and antepartum areas have NC charge nurse. Rotation of NC nurses creates discontinuity of quality of care. Rotating HMs and inexperience adds to this problem. Permanent civilian nurses allows continuity (and training for NC rotating to the service). NC in charge of area must have experience and training in this area in order to properly manage.
Staff Nurse	My tour has been a thoroughly rewarding one. I am very confident of my skills as a high risk L&D nurse. I feel I can walk into any L&D ward and do very well on my attained skills.

50-98 BED-SIZE HOSPITAL	
Director of Nursing Service	I had to ask the CO to close labor and delivery, postpartum and newborn nursery for 3 weeks to send our nurses to [98 Plus Bed-Size Hospital] for training. When these nurses returned, their skills were not only outstanding, but they said they felt so much more confident, because they had the opportunity to care for a large number and variety of patients.
Director of Nursing Service	Survey does not distinguish between experienced vs newly assigned staff - Example - 50 % of my L&D staff are senior civilians who are experts in their specialty; however, the remainder of the staff that I must supply to that area are usually [nurses with subspecialty code] 1900s without any L&D experience. Through OJT, novices become expert but at a small command it can take over 12 months to reach that level of performance. There is no way to select a performance level 1-9 that is uniformly representative, so results are misleading.
Division Officer	Military nurses are not routinely assigned to OB/GYN unless overseas or as charge nurse. The majority of MTFs utilize civilian nurses. This is frequently a disservice to the military nurse wanting to train in maternal child care.
Obstetric/ Gynecology Surgeon (OCONUS)	Specialized training for L&D is very helpful. Unfortunately, the nurses always transfer in and out from other units making L&D less efficient.
Staff Nurse	Due to our current limited number of deliveries, it is difficult to provide the many experiences necessary for a new nurse to feel comfortable working alone in a reasonable amount of time.
BELOW 50 BED SIZE HOSPITAL	
Director of Nursing Service (OCONUS)	I have one opportunity one time a year for two weeks to send one nurse into the local hospital to get some OJT in obstetrics and newborn nursery.
Director of Nursing Service	Our biggest problem is in OB/Newborn. We need experienced nurses in this area. Presently, we have one and she does a fine job teaching RNs and corpsmen.

BELOW 50 BED-SIZE HOSPITAL (continued)	
Assistant Director of Nursing Service (OCONUS)	Average 40 deliveries/month, yet in past 2 years no Nurse Corps officers have PCSed with OB/Newborn skills or experience! Have capability of putting in Fetal Monitoring course, but not cost-effective because not enough staff to cover workload and send staff to class. All didactic training has to be TAD; frequent cancellation of intended courses at other MTFs. All training OJT, but frequently interrupted because orienting nurse has to go back to another area to cover.
Nurse Midwife (OCONUS)	No comments on survey except that I am very happy to see a high-level of interest in this area. Obstetrics is a high-risk area for litigation and more and more RNs are now named in suits. Adequate initial and on-going education in perinatal nursing is essential to provide high-quality care, to minimize litigation risks, and provide increased satisfaction to nurse and physicians in area, thus increase retention of NC officers and OB/GYN physicians.
Department Head	Currently have no formally-trained OB/GYN or L&D nurses. None have attended formal Fetal Monitoring course. None except midwife belong to NAACOG. OR staffed by 2 OR nurses, calls shared with clinic nurses and nurse practitioner! L&D nurses not trained to do OR. Nearest civilian facility doing OB is 80 miles away.
Obstetric/ Gynecology Surgeon	The only real complaint I have about this hospital that I see as a very real problem, that I cannot work around (although, I am quite successful), is that the nurses are not trained to work in this setting. They are all very kind, willing to learn, eager, and bright (although none of this was true of one that just left) but they have little or no practical OB experience. There is one nurse with much experience who can do it all, but the rest (5 other nurses work the ward) have no experience in the one specialty that is the predominant specialty here. If an emergency occurs here, it is most likely that with the 12-15 deliveries per month done here, OB will be the emergency! Fortunately, I have always been very interested in the nurses' role and have paid attention to what they do, so I can teach them some of the things.. although an emergency is no time to be training, especially when you have so little help!

BELOW 50 BED-SIZE HOSPITAL (continued)	
Obstetric/ Gynecology Surgeon (OCONUS)	Navy Nurse Corps officers are so inundated with ancillary duties and paper-pushing that they cannot devote time to reading and learning. Once they develop OJT experience (which in a small hospital takes at least 2 years) they are transferred to an unrelated field or non-patient care position. Much responsibility has to be shared with Corps staff and they do not spend enough time at one job to become proficient (at my hospital they go from wards to administration).
Staff Nurse (OCONUS)	It would be nice if nurses were trained in OB/newborn nursery prior to overseas assignment. Smaller facilities do not have the resources to provide such training.
Staff Nurse (OCONUS)	I am very pleased to see this survey and the manner in which it is written. In a facility such as ours, overseas, < 50 beds, formal training for the obstetrical and neonate nurses is gravely important and not always respected as so by the senior nursing management. This is an extremely litigious field of nursing and the nurses are required to work alone, often without an obstetrically trained physician in house, with only 5 weeks of OJT, and no obstetrical or neonate background. It would be of great service to replace nurses at this facility, one-to-one for specific area of training.
LOCATION MISSING	
Staff Nurse (OCONUS)	When I first started working in the nursery, I received only OJT. There was a lot I did not know along the way and I'm sure there is a lot left for me to learn in my area. It would have been very helpful to have received formal training in the area of Level I and II nursery before I started working on my own. It was not possible at the time due to staffing. A year after I was at this job, I received an NALS class. This was what I should have learned before working in the nursery.

Psychiatry

FAMILY PRACTICE HOSPITAL	
Division Officer	I suspect that this survey (at least the psychiatric nursing portion) was constructed by a non-registered nurse. It reflects little understanding of nursing practice, nursing theory, or the fact that nurses, particularly on psychiatric units, make independent decisions and implement actions without specific orders. I seriously doubt that, if examined by a group of psychiatric nurses, particularly those with advanced education, that this survey would demonstrate content validity. Finally the survey overall addresses skills. Psychiatric nurses need to be theory-grounded to analyze what is present and how to respond. It is not like taking a temperature or changing a dressing that anyone can be trained to do, although this is the way the specialty is treated.
Psychiatrist	Our nursing staff is SUPERB!!! We have no inpatient psychiatry service. Thus, psychiatric cases are managed in the emergency room or on the general medical ward. Cases requiring more than crisis intervention are generally transferred to military medical centers with psychiatric inpatient units. Our outpatient psychiatric clinic functions with neuropsychiatric technicians (nurses not involved). Our ARD [Alcohol Rehabilitation Department] has minimal nurse involvement.
Psychiatrist	Overall the nursing care here is excellent for the limited exposure they have to psychiatric patients. We have no inpatient psychiatric unit and those patients who receive hospitalization are placed on a general medical floor prior to their transfer to a long term inpatient psychiatric facility.
98 PLUS BED-SIZE HOSPITAL	
Department Head (OCONUS)	I tried to answer the survey as accurately as possible for my MTF. There are, however, no psychiatric technicians or psychiatric nurses assigned to the inpatient ward. There is no real milieu environment
Division Officer (OCONUS)	Many of the questions while applicable to my specialty do not address my current position as Division Officer in an Alcohol Rehabilitation Division. There is less emphasis on acute psychiatric intervention and more on group leadership and assessment skills here. The addition of a psychiatric clinical specialist in this unit has potential for dynamic representation of NC officer in expanded roles - especially in the aforementioned areas in addition to group supervision. Thanks for the opportunity for input.

98 PLUS BED-SIZE HOSPITAL (continued)	
Division Officer	There wasn't any place to say "not applicable," such as ECT [electroconvulsive therapy]. If I left it blank, then it meant I didn't want nurses performing it. I only filled out training part, as we do not do ECT.
Division Officer	The Navy Nurse Corps currently downplays clinical tracts and clinical specialists. Why did I go DUINS for MS in psychiatry if I cannot practice clinically, and am told in career counseling by DNS to get out of psychiatry if I want to get promoted. Certainly have not felt supported at this command or anywhere I have worked in psychiatry.
Division Officer	Excellent use of tasks, skills, and knowledge items, however, "performance level of nurses" allows for too broad an interpretation of appropriate care, according to current psychiatric nursing protocols.
Psychiatrist (OCONUS)	Many, if not most, of jobs described for nurses are actually done by psychiatric technicians in psychiatry wards. Most of these skills are more highly developed in trained neuropsychiatric technicians than in general nurses working on psychiatric wards.
Psychiatrist	The psychiatric nurses assigned to our facility are all well motivated, committed, and well-grounded in areas of milieu therapy; psychopharmacology, individual psychotherapy, and group therapy.
Psychiatrist	Psychiatric nursing staff is an integral part in the delivery of quality service to psychiatric patients. Being a member of a treatment team, my reliance on the psychiatric nursing staff is about 50-60% in the final determination and disposition of each individual patient. Therefore, without the complete assistance of the nurses, success in the delivery of good quality services is almost NIL.
Psychiatrist	After 9 years in Navy Inpatient Psychiatry, working closely with Navy psychiatric nurses, I have become convinced: Navy psychiatric nurses are POORLY trained (in psychiatry) compared to community (where I also work) psychiatric nurses. Navy organizational structure encourages nurses to adopt role of supervision of direct care rather than the primary agent of direct care - hence Navy psychiatric nurses are usually less competent than 8485 psychiatric technician. Relative absence of outpatient (and aftercare) treatment programs in the Navy prevents psychiatric nurses from gaining experience off the wards. Excellent inpatient population flow and overall motivation of Navy psychiatric nurses contribute to their overcoming much of their deficit in training and psychiatric knowledge.

98 PLUS BED-SIZE HOSPITAL (continued)	
Staff Nurse	The area of psychiatric care at my command is limited to an ARD, although adjustment disorders (e.g., overeater/codependency are also treated). This command is supportive of continuing education and classes in substance abuse and has recently added several prevention/detection measures pertaining to substance abuse.
Staff Nurse	I feel that, for the most part, nurses at this facility are not supported on the psychiatric unit. They are sent with no training. Our unit is not recognized as just as acute a unit as ICU. There is no time to teach new staff how to run groups, stop disruptive behavior or staff-splitting. We are the second largest hospital and have the least amount of staff and the least trained in this highly specialized field. Management does not realize how dangerous this can be. Our specialty area is not recognized as such.
Staff Nurse	Most of the nurses assigned to this ward (psych) did not ask nor did they desire this assignment. For about 50% of them this appeared to be a place where they were assigned because they have trouble functioning on the busier, more intense wards. Due to the chief nurses policy of rotating nurses to different wards on an annual basis, it was the inexperienced teaching the inexperienced. The reposition of corporate knowledge resided in the psychiatric technicians. Due to the long period of time before one could be eligible to become certified, no one could qualify. The nurses are at a distinct disadvantage as far as training goes. The corpsman, psychiatrist, and psychologist all have specialized training in the field. Of the 20 or so nurses I worked with, only two had any training.
50-98 BED-SIZE HOSPITAL	
Assistant Director of Nursing	This is a complex survey that does not relate to the clientele of this facility or our staffing distribution. There is no Inpatient Psychiatry and very limited Orthopedics from a contract provider. My answers are less than valid because I really do not have a current valid frame of reference for standard of care. I chose to answer based on past experience and my present frame of reference for staff development, but I am not comfortable with this. Also, do you want my thoughts on what new ensigns should know, or what we would like to develop new subspecialty codes into?

50-98 BED-SIZE HOSPITAL (continued)	
Department Head (OCONUS)	The support for nurses in psychiatric specialties needs to be from the top on down. DNSs need to use their people wisely. Utilize psychiatric RNs on psychiatric wards, not general medicine OR, ER, etc., because you need to be a "well-rounded Navy Nurse." Nursing is specializing, just like medicine and there needs to be a sensitivity to this change. Additional training - DUINS is a place to start. There seems to be limited support for DUINS in psychiatric nursing. I was told to pick two areas for DUINS. Of the Navy choices what other masters program is related to psychiatric nursing (clinical specialist)?? No guarantees that if picked up I would be offered my only choice of psychiatric nursing. So I did not apply this year and will seek my master's on my own, once I PCS to CONUS. If I obtain my masters at my expense, why stay in the Navy since this is so highly flaunted as a recruiting hook. Conferences and specialty associations are excellent ways to train, educate, and show support for our RNs in psychiatry. I belong to APNA (American Psychiatric Nurses Association) and have attended all of the conventions (5 of them, the Navy paid for one). I go, learn up-to-date techniques, networking, and then incorporate what I have learned into my Navy practice. Twenty-four CEUs are obtained at these conferences. Detailing by subspecialty would be great, but this is only theory. If this became reality, then some continuity of experience and training could be maintained at the various naval facilities to help with patient care as well as the training of new inexperienced RNs in psychiatry. As an RN working at a civilian hospital, I was required to be with a preceptor for 6 weeks prior to my taking patients. This may not always be possible in the Navy, but 4 weeks of orientation is not enough before an assignment.
Division Officer (OCONUS)	Psychiatric patients; it does not require high tech, high cost machines. Look at the CHAMPUS dollars lost due to the non-availability of psychiatric facilities in the Navy. Psychiatry is a very operational field for active duty. How many casualties were psychiatric related in the last 3 armed conflicts alone, not to mention the sprint team response to disasters. The Army and Air Force encourage specialization in psychiatry. Why does the Navy lag behind? By this questionnaire alone, the number and in-depth questions concerning psychiatry are illustrated. I am encouraged by this questionnaire concerning psychiatric nursing. I hope the Navy is taking a more interested look into psychiatric nursing.

50-98 BED-SIZE HOSPITAL (continued)	
Division Officer (OCONUS)	It has been my experience that psychiatric nursing is viewed in the Navy as less than nursing. My 6 years experience has been such, that if a nurse could not perform or had a "personal problem", the answer was to put them on "psych, since they don't do anything anyway." The training received by the nurses assigned to the psychiatric wards is minimal and even the charge nurses have limited experience, at best, in psychiatric nursing. This creates a mad rush for training. Most is "familiarization" to nurses that really don't want to be in psychiatric anyway. The bulk falls on the psychiatric technicians (if there is no experienced psychiatric nurse 1930S/1930K) who have had 8-10 weeks specialized Navy training and some "hands-on" experience. While qualified to impart information on safety issues such as restraint techniques and maintaining a locked ward; they are not qualified to instruct RNs in the therapeutic one-on-one, psychiatric nursing care plans, group therapy, therapeutic milieu, unconditional positive regard, etc. The result of this form of training is a passive RN, who lets the psychiatric technician dictate milieu and therapeutic interventions due to their lack of experience in this complicated field. This leads to an apathetic response from those nurses who are placed on psychiatric. Psychiatric nursing is one of the first true forms of nursing, utilizing nursing theory (therapeutic one-on-one relationships: peplau) as well as up-to-date nursing experience and research (APNA). The Navy could capitalize on this by making psychiatric nursing more attractive to RNs. After all, this is a low cost investment with high yields. If this is not believed by the Navy, just look at all the private psychiatric hospitals, (I worked in the private sector 5 years prior to active duty). It only requires adequately trained RNs to help.
Staff Nurse (OCONUS)	Psychiatric patients are treated on an adult/pediatric multi-service ward. A high percentage of the Navy nurses working this ward have little to no experience working with psychiatric patients. There is a strong need for a separate psychiatric ward along with billets for nurses to staff the floor. Being fairly isolated, except for the medical system, I believe a high risk is run placing these patients for short term-acute management on this otherwise medical-surgical unit. There is no way to provide group milieu, etc., therapy - There is no way to provide longer terms or effective after care. If they are not acting out, they get lost in the crowd.

50-98 BED-SIZE HOSPITAL (continued)	
Staff Nurse (OCONUS)	Most of the short falls noted are due to staffing, leading to people not being able to attend workshops. Also, there is not a separate psychiatric ward making it more difficult to treat psychiatric patients.
BELOW 50 BED-SIZE HOSPITAL	
Director of Nursing Service (OCONUS)	Many portions of survey do not apply to my hospital since we do not have a psychiatric unit. Milieu treatment would not fit the needs of patients in my hospital. Assignment of nurses is often mismatched since we do not usually have psychiatric nurses assigned. If a psychiatric nurse is assigned, assignment is as a general nurse. General nursing, not psychiatric experience, is sought from the nurse, who is rated by the standards of general nursing.
Assistant Director of Nursing Service	Psychiatry: We do not have inpatient psychiatry, so skill level is very low, but if MTF did admit psychiatric patients and had a psychiatric ward, nurses would receive good "hands-on" skills.
Assistant Director of Nursing Service	Psychiatric patients may be admitted on a case-by-case basis, with a special watch (if indicated) supplied by psychiatric department. If no watch required, our staff may be called upon to care for the patients on a short-term basis. Most of our psychiatric patients are medevaced to (Major Teaching Facility) or admitted to civilian facilities in the local area.
Assistant Director of Nursing Service (OCONUS)	With adequate training, nurses can do majority of discussed items, but the size and resources of facility do not always allow for the care to be given at a facility. Psychiatry is a pointed example. Psychiatric patients are kept on a general ward and receive treatment in mental health clinics. Nurses are minimally involved in psychiatric care. Ward setting is more that of a secure room with staff to provide one-to-one watch.
Department Head	In general Navy nurses do not demonstrate good psychiatric skills or knowledge.

BELOW 50 BED-SIZE HOSPITAL (continued)	
Department Head (OCONUS)	In our OCONUS hospital the NC do the best they can, but none have any psychiatric training and the only admissions are for acute, dangerous patients. There are no psychiatric beds per se, no isolation or quiet room and patients are placed on one-to-one watch or in restraints, if needed. The NC staff mostly does not like psychiatric patients and are generally relieved when discharge time occurs. Few show any basic knowledge of psychiatry.
Division Officer (OCONUS)	The general ward staff nurse is not at all prepared to deal with psychiatric patients. When psychiatric patients are admitted to a multi-service ward, it is, indeed, a challenge for those nurses, not to mention how the patient is cared for.

General Comments

FAMILY PRACTICE HOSPITAL	
Division Officer	Highly recommended formal training (required and offered) in the areas of psychiatry, OB, and Orthopedics. OB/GYN OJT approximately 2 years. Psychiatric OJT approximately 5 years and Orthopedic OJT 3 years.
Division Officer	Lots of verbal encouragement and support for personnel to receive training and obtain certification. But, it's very difficult with minimal staffing and funding.
Staff Nurse	Training should be available in these areas, where nurses can pick up a specialty and be certified by a board, i.e., CCRN. I believe many Navy nurses are looking for an opportunity like this to enhance their knowledge and better serve our shipmates.
Staff Nurse	Poor orientation. Little support for additional training in specialty areas. [My specialty is] not treated as specialty area at this facility.
Staff Nurse	The Navy seems to hold people back from further study when it would greatly benefit if more staff were encouraged and helped to further their education. Perhaps grand rounds should be minimized when case studies could be presented on a monthly basis, more inservice education. The staff and the clients would greatly benefit if naval hospitals became learning facilities for nurses as well as corpsmen, doctors, the whole medical team.
98 PLUS BED-SIZE HOSPITAL	
Assistant Director of Nursing Service	Current graduates do not receive enough pharmacology in school! The facilities need a follow-up program to assess medication knowledge and instruct in areas of knowledge deficit.
Department Head	Nurses are too frequently assigned outside their specialties. When transferred, frequently there are "no guarantees" of being assigned in their specialty. No one assigns a pediatrician to work in an orthopedics clinic! Also, the "Nurse of the Day" concept is becoming dangerous since so many fields are quite technical and no one can know everything about all specialties any more. What's the use becoming certified in mental health, if you'll be assigned to an orthopedic ward and do NOD in a hospital with no psychiatric services?

98 PLUS BED-SIZE HOSPITAL (continued)	
Department Head	I would like to see the Navy offer a unified course for each of these areas with certification and subspecialty codes, such as we have with OR school.
Department Head	Nurses do a good job taking care of specialty patients, considering the amount of training they get. Many request and are granted TAD for training. There are no minimum requirements for psychiatry and orthopedics, as there is with OB.
Division Officer	Hints on how to successfully set up RDMF, FM, etc.
Division Officer	Basic education sufficient - Need more funds for continuing education opportunities - many worthwhile courses not attended by staff due to lack of funds. Need more educational opportunities.
Staff Nurse	Definitely need to include more in-depth courses to enhance our OJT, not just a select few.
Staff Nurse	Need to focus on more of an operational track. Due to our recent deployment in Operation Desert Shield/Storm, it showed how unprepared we were in a casualty environment. We were fortunate to have had the Desert Shield time to prepare. - glaring lack of emergency & trauma skills - need to stress our role as military nurses - gross unfamiliarity with equipment used in the field - need to parallel our dependant care with operational training - i.e., OB/nursery work and C4, RADMF training. - need to interface with the line community on their level and in their environment.

98 PLUS BED-SIZE HOSPITAL (continued)	
Staff Nurse	Any nurse who works in these subspecialty areas needs additional training. Our basic nursing education center around medical-surgical nursing. We have very little practical experience in these areas. Navy nurses should be able to specialize in a particular field and then be expected to be placed in a hospital billet that can use that expertise. It has been my experience in talking with other Navy nurses, that this is not the normal practice. I understand the concept of "needs of the Navy", but feel the present practice of filling a particular billet with whoever is available is very costly and ineffective. Let nurses chose 1-2 subspecialties in addition to medical/surgery and then let them work these areas exclusively. The patients would get quality care and in the long run this will probably prove to be less costly.
Staff Nurse (OCONUS)	Need lots! Unfortunately, the excuse of "not enough staff" or "not enough money" is all too popular.
Staff Nurse (OCONUS)	The majority of training is OJT. I would recommend a Navy-wide manual with a certification test be set-up rather than have each hospital decide on what certification they feel is minimum requirements. Certification in one institution does not transfer. This is frustrating and insulting.
Staff Nurse (OCONUS)	Unfortunately, this survey will only partially depict these needs of the nurse corps. There are so many other needs that are not nearly touched upon.
50-98 BED-SIZE HOSPITAL	
Staff Nurse	I believe that specialty training is needed in all of these areas. Yet too often, the shortage of need for staff breaks the receiving of training needed. Also, the Command's perception of the need for training or monies available for nursing service continued education affects training availability.
Staff Nurse	Work on multi-service ward, medical/surgical being largest composition of patients. There are not any critical care areas to work with or to get experience with, the only specialty areas are L&D and newborn nursery.
Staff Nurse	Focus on additional administration training related to hospitalization/medical records paperwork.

50-98 BED-SIZE HOSPITAL (continued)	
Staff Nurse	The Navy Nurse Corps needs to honor specialties when one is held. I believe the "well rounded nurse" policy is very damaging to not only the patient care delivery/quality, but also the nurse corps as a whole. Nurses specialized in an area of care due to interest, natural ability, and fulfillment. When these are taken, the nurse becomes "unhappy", unfulfilled, morale declines, resulting in lower retention. PLEASE, honor specialties and decrease the mood of "jack of all trades, master of none", and increase the nurse corps retention and moral.
Staff Nurse (OCONUS)	Survey brings up just how poorly trained we are to handle the type of multi-disciplinary work we do.
Staff Nurse (OCONUS)	More structured "knowledge learning" - classroom instruction very helpful in these specialty areas. Preceptorship not adequate to learn the job to expected satisfactory level.
Staff Nurse (OCONUS)	This hospital cross trains its own staff on a one-to-one basis. The area resources and funding does not provide for extensive outside training. Even in the small CONUS hospitals we were expected to pay our own way on our own time to attend training or seminars. Yes, training is needed, but it is only possible if you are stationed in a metropolitan area.
LESS THAN 50 BED-SIZE HOSPITAL	
Department Head	Experienced nurses needed in small hospitals. We do not have assets to cross-train and cannot afford TAD because it leaves too little staff behind. Whatever happened to experienced Corps staff on L&D? Nurses could be much more effective if their Corps staff were trained better in Corps school.
Obstetric/ Gynecology Surgeon (OCONUS)	Nurses need OJT experience. They do not benefit from going from ER to NEURO to OB and the patients care suffers.
Staff Nurse	We need a formal orientation program, not just OJT time. Nurses should be allowed to progress at their own pace.

Appendix F: Support and Encouragement of Training: Tables of Responses by Staff Nurses and Supervisiors

Table 13

The Extent Nurses are Encouraged by Senior Management to Seek Additional Specialty Training: Response by Staff Nurse Corps Officers

Specialty Area	Extent of Encouragement by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=100)	42	28	13	10	7
Obstetrics/ Newborn (n=112)	24	17	30	16	13
Psychiatry (n=67)	52	19	13	6	9

Note. Percentages may not total 100 due to rounding.

Table 14

The Extent Nurses are Encouraged by Senior Management to Seek Additional Specialty Training: Response by Supervisors[a]

Specialty Area	Extent of Encouragement by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=62)	36	18	27	13	7
Obstetrics/ Newborn (n=70)	7	13	26	30	24
Psychiatry (n=65)	34	15	20	22	9

Note. Percentages may not total 100 due to rounding.

[a]Based on 101 Directors of Nursing Service, Assistant Directors of Nursing Service, Nursing Service Department Heads, and Division Officers

Table 15

The Extent Financial Resources are Available For Nurses to Obtain Specialty Training: Response by Staff Nurse Corps Officers

Specialty Area	Extent of Availability by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=86)	40	28	24	6	2
Obstetrics/ Newborn (n=104)	26	32	21	18	3
Psychiatry (n=62)	47	21	23	5	5

Note. Percentages may not total 100 due to rounding.

Table 16

The Extent Financial Resources are Available For Nurses to Obtain Specialty Training: Response by Supervisors[a]

Specialty Area	Extent of Availability by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=59)	25	29	15	25	5
Obstetrics/ Newborn (n=65)	25	25	14	28	9
Psychiatry (n=61)	31	23	10	30	7

Note. Percentages may not total 100 due to rounding.

[a]Based on 101 Directors of Nursing Service, Assistant Directors of Nursing Service, Nursing Service Department Heads, and Division Officers

Table 17

The Extent Manpower Resources are Available to Permit Nurses to Seek Additional Specialty Training: Response by Staff Nurse Corps Officers

Specialty Area	Extent of Availability by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=99)	52	19	14	12	3
Obstetrics/ Newborn (n=114)	41	22	15	15	7
Psychiatry (n=72)	56	15	7	15	7

Note. Percentages may not total 100 due to rounding.

Table 18

The Extent Manpower Resources are Available to Permit Nurses to Seek Additional Specialty Training: Response by Supervisors[a]

Specialty Area	Extent of Availability by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=63)	25	25	18	21	11
Obstetrics/ Newborn (n=67)	19	27	18	24	12
Psychiatry (n=60)	25	23	22	18	12

Note. Percentages may not total 100 due to rounding.

[a]Based on 101 Directors of Nursing Service, Assistant Directors of Nursing Service, Nursing Service Department Heads, and Division Officers

Table 19

The Extent Nurses Seek Specialty Training in Preparation for Current or Projected Reassignments: Response by Staff Nurse Corps Officers

Specialty Area	Extent That Nurses Seek Training by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=80)	54	20	14	13	0
Obstetrics/ Newborn (n=101)	28	28	18	22	5
Psychiatry (n=60)	52	20	10	13	5

Note. Percentages may not total 100 due to rounding.

Table 20

The Extent Nurses Seek Specialty Training in Preparation for Current or Projected Reassignments: Response by Supervisors[a]

Specialty Area	Extent That Nurses Seek Training by Percentage				
	Very Small Extent	Limited Extent	Moderate Extent	Considerable Extent	Great Extent
Orthopedics (n=57)	49	25	18	5	4
Obstetrics/ Newborn (n=60)	13	25	20	20	22
Psychiatry (n=53)	45	26	13	4	11

Note. Percentages may not total 100 due to rounding.

[a]Based on 101 Directors of Nursing Service, Assistant Directors of Nursing Service, Nursing Service Department Heads, Division Officers